THE CANADIAN HOSPITAL

OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL

DECEMBER, 1947

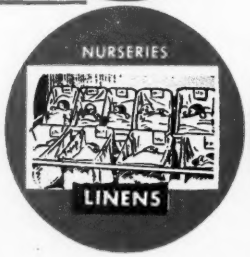
Patients frown on linen rationing

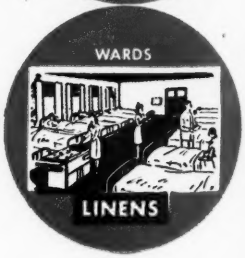
● Patients naturally frown when linen shortages affect their personal comfort. Morale drops. Complaints come fast. Hospital prestige suffers. All because increased occupancy requires more clean linens than your overburdened laundry can supply.

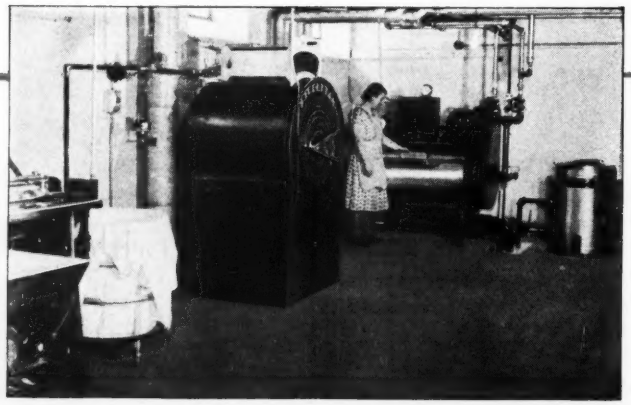
● *Modernize* the laundry. It's the simple solution that pays big dividends. Up-to-date machines turn out more laundered linens in less time. Linen stocks are replenished on shorter schedule. Every department has plenty of clean linens always available. Yet, you require less inventory. Your linens are more attractive. And you save real money through big reductions in operating costs.

● Your laundry's importance to the hospital demands you give it your serious attention NOW. Take advantage of a free survey by our Laundry Advisor. WRITE TODAY.

REMEMBER— Every Department of the Hospital Depends on the Laundry



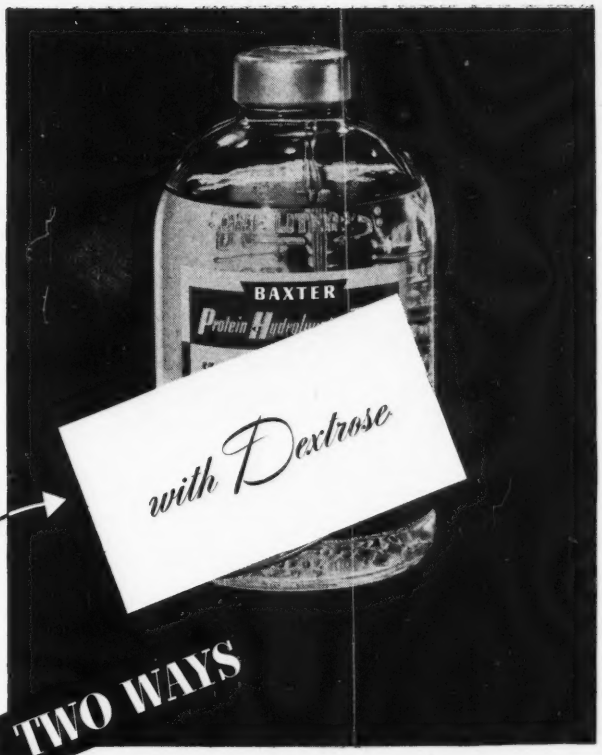




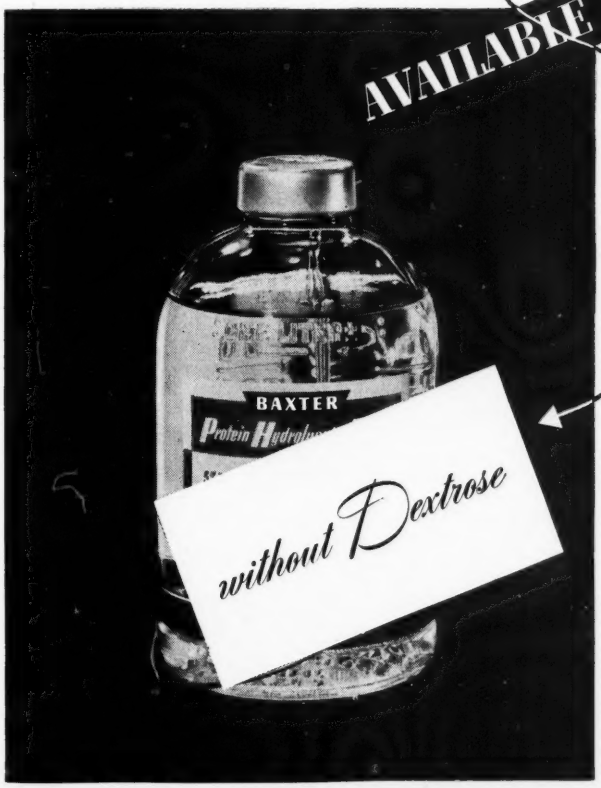
50-bed Dakota Hospital, Vermillion, S. D., modernized their laundry with this efficient American 4-Machine Unit. Reported: "New laundry works like a charm. We are gratified with economy of time and materials, simplicity, lovely snow-white linens."

The
CANADIAN LAUNDRY MACHINERY CO. LIMITED
47-93 STERLING ROAD, TORONTO 3, ONT.

Protein Hydrolysate Baxter



AVAILABLE TWO WAYS



For flexibility in protein hydrolysate therapy, Baxter gives you two solutions—5% Protein Hydrolysate and 5% Protein Hydrolysate with 5% Dextrose. Autoclaved to assure sterility, these solutions meet the same high standards applied to all Baxter products.

The unique flexibility is characteristic of the integrated Baxter program of parenteral therapy with its wide selection of solutions, equipment and standardized procedures. No other method is used by so many hospitals. Write for full information and literature.

Baxter *PIONEER NAME IN PARENTERAL THERAPY*

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BAXTER LABORATORIES

Morton Grove, Illinois · Acton, Ontario

Distributed in Canada exclusively by

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TORONTO

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Contents

Vol. 24 **DECEMBER, 1947** No. 12

Number 10 in a series

Burton Eugene Baker

Devoted his life to the x-ray tube

IT wasn't easy for Burton Baker, a business-college graduate, to educate himself in the basics of electrical science.

But this was Baker's favorite topic—and he learned all he could. He decided, when the news was released about the roentgen ray, to devote his whole life to this miracle.

His greatest success in the x-ray field was the development and manufacture of tubes of especial form and function, such as valve tubes for current rectification.

Again and again Baker demonstrated the effectiveness of these tubes to anyone who showed interest, almost always using himself as a subject. These demonstrations, coupled with the close watching of the tubes during the process of exhaustion, brought about persistent ulcerations on Baker's hands, face, and chest.

For ten years these maladies gave him much pain. Yet he continued with his work, and developed a new static machine.

In 1913 his condition necessitated 10 operations—all unsuccessful. That July he died of metastatic carcinoma—an obscure man who had given all he had to the science of x-ray.*

• • •

To further the science such men as Baker pioneered, Ansco has long employed a large staff of scientists. Their aim: To develop the very finest x-ray films and chemicals possible.

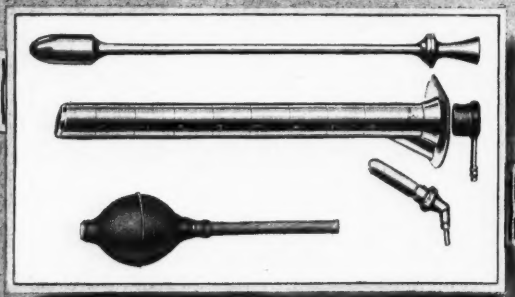
One such chemical, developed by these scientists, is Ansco Liquafix. A liquid-type fixer that clears films faster because it has a special, faster-acting agent which replaces the customary "hypo." Liquafix will process up to 30% more films, too.

Available for immediate delivery, Ansco Liquafix and all the other products in Ansco's x-ray line are available to bring you clearer radiographs of high diagnostic value.

Ansco of Canada Limited,
60 Front Street West,
Toronto 1, Ontario.

*"American Martyrs To Science Through The Roentgen Rays," by Percy Brown, M.D. Published by Charles C. Thomas, Springfield, Ill.

Yeomans'



Proctoscope.

The Yeomans' Proctoscope consists of a tube 10 inches long, with a working length of 8 inches graduated in eight one-inch divisions. Its distal end is slightly oblique, and the proximal end is fitted with a large flange having a milled edge. A small segment is cut from one side to prevent rolling. An auxiliary tube to accommodate a light carrier perforates the flange and joins the main tube at an angle.

Illumination is direct, and is obtained from a small powerful electric bulb covered with a capsule holding a plano-convex lens so set that the collected rays are refracted at a compensating angle to the light carrier. The light carrier fits accurately into the auxiliary tube by means of a conical fitting so that only the lens projects into the main tube. Therefore, all the rays are focused at the distal end. The vision of the observer, and the path for the introduction of the instruments for examination, local application or operation are always clear, there being no obstruction.

A lens cap closes the proximal end of the proctoscope tube and contains a glass window which magnifies the illuminated field at the distal end of the tube. Fastened to the side of this lens cap is a nipple which provides for the attachment of a hand bulb to inflate the bowel. The conical fittings of the lens cap and light carrier prevents the escape of air when pneumatic pressure is applied. The obturator has an olivary tip which facilitates the introduction of the tube. The tubes are made in various sizes:

Proctoscope Tube 10 inches long (8 inch working length), ¾ inch in diameter.
Proctoscope Tube 12 inches long (10 inch working length), ¾ inch in diameter.
Infant Proctoscope Tube 10 inches long (8 inch working length), ½ inch in diameter.
Sigmoidoscope Tube 14 inches long (12 inch working length), ¾ inch in diameter.

The same light carrier fits all the above tubes. In practice, it will be found that the most useful size which will fill the requirements in the majority of cases is the 10 inch by ⅞ inch tube. (8 inch working length).

The entire instrument may be carried in the physician's bag, and for this reason it is supplied without a case. All parts of the instrument which come in contact with the patient may be sterilized by boiling.

YEOMANS' PROCTOSCOPE

Yeomans' Proctoscope (Catalogue No. 293) complete with 10" x ⅞" tube and obturator, light carrier, conducting cord, lens cap, lamp and inflation bulb, without case.

ESTABLISHED IN 1900 — BY REINHOLD H. WAPPLER.

F. J. Wallace, Pres.

AMERICAN CYSTOSCOPE MAKERS, INC.

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INGRAM & BELL LIMITED

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MONTREAL • WINNIPEG • CALGARY • VANCOUVER

Braided for non-slip knots . . .
. . . black for identification

. . . Black Braided NYLON SUTURES

Surgeons who prefer Black Braided Nylon — for its firm, non-slip knots — for its visibility in tissue — find these important characteristics in Ethicon:

1 — Ten diameters in compliance with U. S. P. silk specifications (5-0; 4-0; 000; 00; 0; 1; 2; 3; 4; 5.

2 — Maximum tensile strength (in excess of U. S. P. requirements for silk) both straight and knot pull, in any given size-designation.

3 — Color-fastness during sterilization and in tissues.

4 — Moisture and serum-proof; non-irritating; non-capillary even after sterilization.

5 — Uniform braiding to assure smooth knots.

These characteristics make Ethicon Black Braided Nylon* the outstanding suture material where use of braided nylon is indicated.

***NOTE TO HOSPITALS:** Ethicon Black Braided Nylon is available in 25 yd. spools and the economical 100-yd. spools. These may be combined with Ethicon Braided Silk to earn quantity prices.

ETHICON Sutures — Johnson & Johnson LIMITED MONTREAL

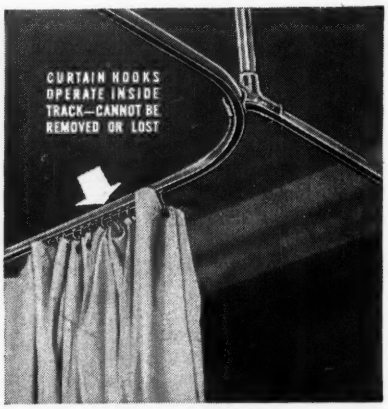
Across the Desk

By C. A. E.

Capital Cubicle Patented Feature Eliminates Lost Curtain Hooks

One of the outstanding reasons for the widespread acceptance of Capital Cubicles throughout Canada and the United States is a patented feature which eliminates the old bugaboo of lost hooks and the scratching of polished surfaces.

Capital curtain hooks operate inside a 14 gauge brass, chrome plated track with an open channel in the bottom, and two parallel inner tracks upon which the hooks slide freely. This feature eliminates the



usual complaints of hooks catching and jamming—assures quick, quiet and dependable operation—prevents removal or loss of hooks, and as the polished surface cannot be scratched, does away with costly replating.

For wards, semi-private, first aid, private or examining rooms, Capital Cubicles are easily installed by any mechanic. Each cubicle and curtain is numbered, and accompanied by plan sheets and detailed instructions.

The curtains, non-transparent and sanforized, come in white and restful fast colors; substantial rust-proof eyelets are guaranteed not to pull out or stain the cloth. Completely informative, illustrated literature will be mailed upon request to the Capital Cubicle Co., Inc., at 213 Twenty-Fifth Street, Brooklyn 32, New York.

* * * *

Stafford's New Labels

J. H. Stafford Industries Limited, internationally known manufacturers of basic food materials and soda fountain accessories, have recently redesigned the labels for their popular Sundae Sauces.

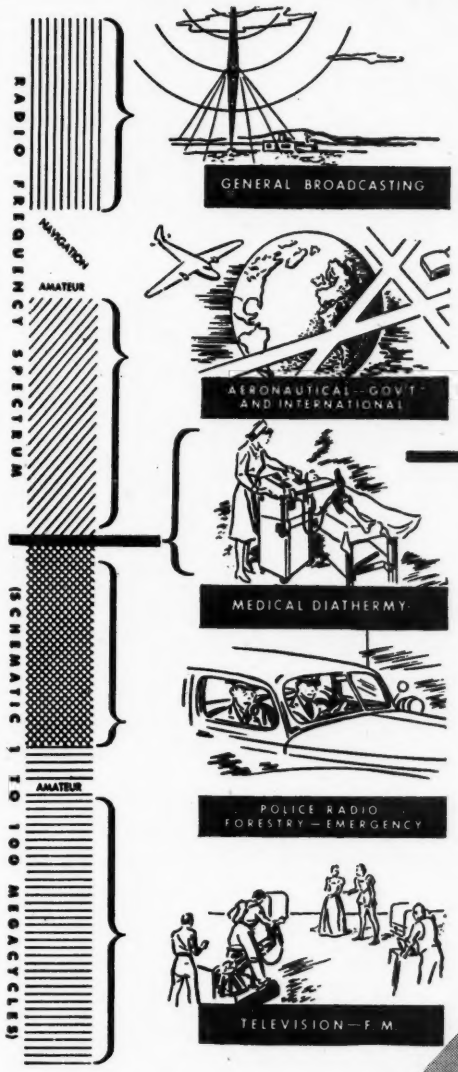
Using the Stafford colours, maroon and cream, the new labels are very attractive and are more readily recognized.

(Continued on page 16)

CANADIAN GOVERNMENT APPLIES CONTROL

TO DIATHERMY FREQUENCIES

Dept. of Transport, Radio Division Acts to Minimize Diathermy Interference to Radio and Television Services



27.12 MC

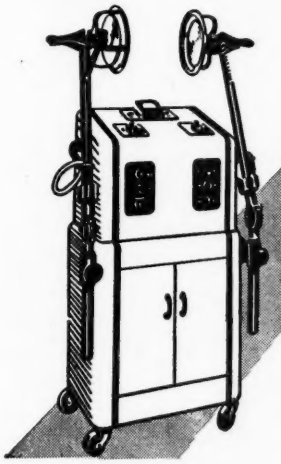
With allocation of specific frequencies and tolerances, D. of T. has found a way to solve the problem of diathermy interference to the varied public, private, and government communications services which have become so important in modern times.

As all diathermy machines "broadcast" radio waves, it is easy to see that these "waves" (depending on their frequency), are capable of serious interference to important services such as police radio, airplane navigation and landing beams, military communications or maritime navigation, as well as television, FM, and regular broadcasting.

By assigning definite bands in the radio frequency spectrum to diathermy use and by setting limitation tolerances for these bands, the government has provided for the effective solution of the problem as is illustrated in the schematic diagram on the left. Just as one radio station confines its "broadcasting" to a specific channel to prevent interference with other stations, so will diathermy, under the new regulations, be confined to a frequency channel of its own.

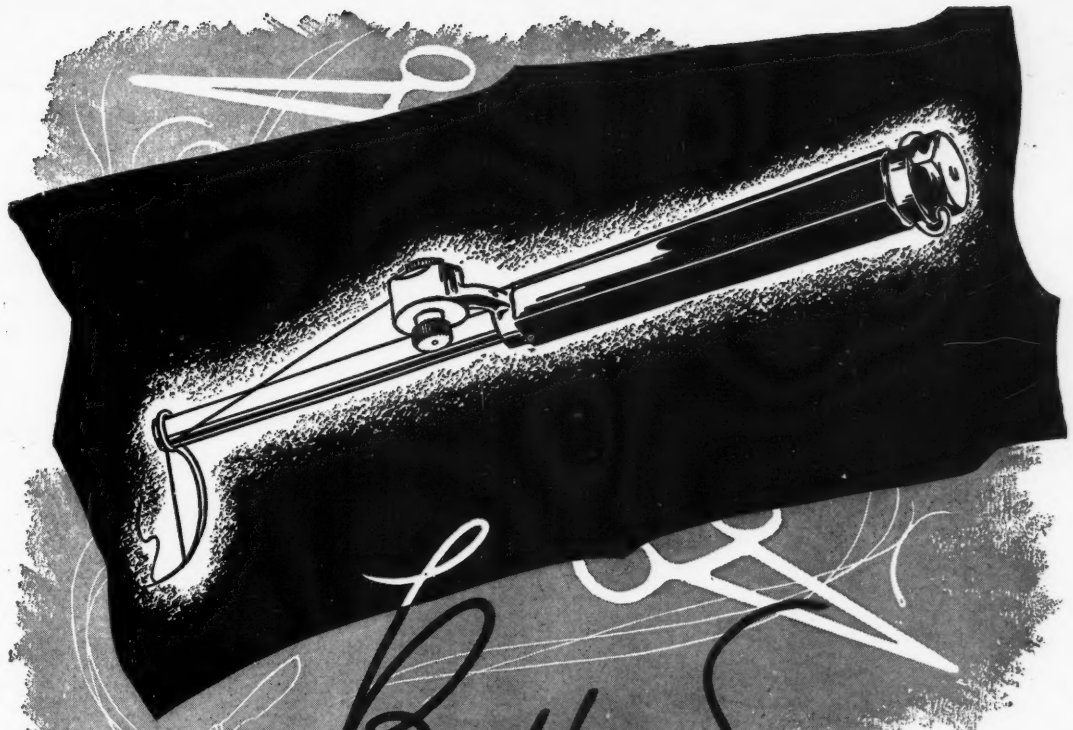
The L-F Model SW-227 Frequency-Controlled Diathermy Unit operates on the 27.12 megacycle frequency allocated by D. of T. Its circuit incorporates an original and exclusive electronic development — The Wavemaster — which monitors set limits within the allocated channel and prevents any shift outside these limits.

Approved! D.T. Listing No. 4



SW-227 Frequency Controlled
DIATHERMY UNIT
AVAILABLE NOW

FERRANTI-ELECTRIC LIMITED
X-RAY DIVISION TORONTO ONTARIO
CSA APPROVED CANADIAN MADE X-RAY EQUIPMENT



Better Surgery

WITH FASTER AND MORE EFFICIENT SUTURING

Hailed by many surgeons as a major contribution to better surgery, the unprecedented speed and efficiency of the Singer Surgical Stitching Instruments are the logical outcome of combining in one functional unit the hitherto separate entities of needle, needle holder, suture supply and severing edge. • Discriminating surgeons who have adopted the Singer instruments report a gratifying freedom from most of the mechanical difficulties common to the suturing phase of operations: stitch limitations because of limited suture supply, crushed needle eyes, slipping and dropped needles, contaminated loose thread ends and constant hand-to-hand dependence on assistants. • For complete information on the many outstanding advantages inherent in these instruments, ask for the fully illustrated booklet.

Bobbin-wound sutures (catgut, cotton, nylon, silk) available through Davis & Geck, Inc., Brooklyn, New York.

* *Our three newest films available for showing are (1) "Rehabilitation of Parkinson's Syndrome", (2) "Treatment of Major Neuralgias", and (3) "Removal of Tumor of the Bladder".*

SINGER

SURGICAL STITCHING INSTRUMENTS

Singer Sewing Machine Company
Surgical Stitching Instrument Division, Canada
Dept. C.H. 127

Without obligation, please send copy of illustrated booklet.

Name .....

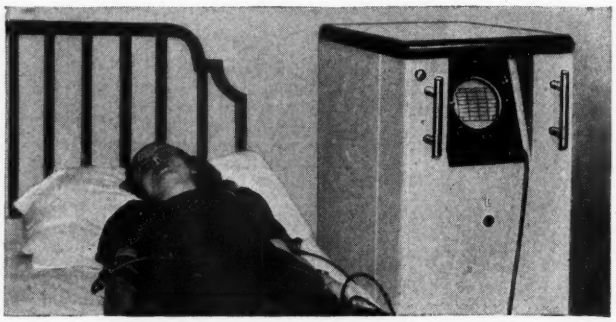
Address .....

City ..... *Prov.*.....

Across the Desk

New Hospital Model Cathode-Ray Electrocardiograph

A new hospital model of the Smith & Stone Cathode-Ray Electrocardiograph is now available for immediate delivery, according to Controlite Engineering and Sales Ltd., Electrocardiograph and Instrument Division, exclusive distributors, 20 Bloor St. West, Toronto. The new hospital model is available for 25 cycles, 60 cycles and 66 2/3 cycles current. While it embodies all the clinical and technical advantages of the portable, two-unit model, the S & S hospital model has, in addition, several new features.



Outstanding is its simplicity of operation which reduces accidental damage by incorrect setting of the controls to a minimum. Another advantage of the hospital model is the recessed, slanting control panel and visual reading screen which permits greater ease of observation and more accurate records by the operator.

Because the Cathode-Ray tube—the highest speed recorder made—is free from inertia, accuracy of the S & S Cathode-Ray Electrocardiograph is assured. In addition, the time marker is accurate and independent of paper speed, while the standardization voltage—connected in series with the patient—can be shown on each lead of the record, thus leaving no doubt as to correct standardization.

* * * *

Jimmy Phillips Passes

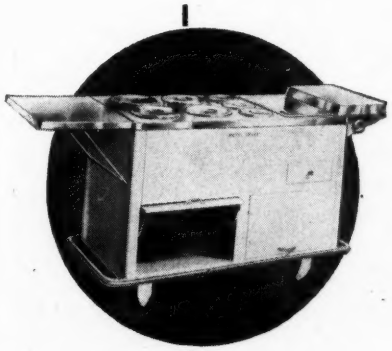
His multitude of friends in the Canadian Drug and Hospital Trades will regret to learn of the death of James C. Phillips in Montreal on October 21st. Mr. Phillips was in his 74th year.

"Jimmy" Phillips, until his retirement in December of 1944, was connected with the Bauer & Black sales organization. During his 35 years with Bauer & Black, he made friends in nearly every province of Canada.

(Concluded on page 20)

DELIVERIES FROM STOCK!

Due to an over run of No. 4431 we are now in a position to ship from stock — provided you order your requirements at an early date.



"OUT THEY GO!"

It would be very convenient if you could conduct a "clearance" when overcrowding is severe. That's impractical, of course, but what you can do is to help shorten the convalescence of your patients by serving meals they really enjoy!

With Metal Craft Food Trucks you convey the full appetite-appeal of every meal from kitchen to bedside. That's because these more efficient food trucks are scientifically designed for automatic temperature-controlled, flavour-saving food distribution.

Get the facts about their many convenience features and exclusive structural advantages. Write for specifications and prices on this model now available for prompt delivery.

The METAL CRAFT CO.
GRIMSBY LIMITED ONTARIO

Across the Desk

Distributors Provide Entertainment for O.H.A. Delegates

Last month, at the Ontario Hospital Association convention, Royal York Hotel, Toronto, business was put aside temporarily while those attending the banquet proceeded to the concert hall where they were treated to an excellent variety show.

The show was sponsored by the exhibitors at the convention, and the program was varied and entertaining. The legedermain of one performer drew considerable applause as did the baritone singer. It is unfortunate that the public address system of the hotel caused some distortion of the voices. This occurred not only during the variety show, but also earlier in the evening, at the banquet, when Mrs. M. J. McHugh sang several favourite songs. However, despite mechanical difficulties, the audience enjoyed the entertainment; credit goes to the performers and thanks are extended to those responsible.

* * * *

Denver Chemical Enlarges Plant

Dr. John Henry Beckley, Medical Director of The Denver Chemical Manufacturing Company, Limited, has announced the opening and full-scale operation of a modern production unit at the Company's Montreal laboratories, 286 St. Paul Street West, for the preparation of Galatest and Acetone Test (Denco) — two diagnostic reagents manufactured exclusively by The Denver laboratories.

These tests, known to the trade and medical profession as "Spot Tests" are dry reagents for the immediate detection of urine sugar and acetone in the urine. A drop of urine on a small amount of these specially prepared powders results in an immediate colour change depending upon the percentage of sugar or acetone present.

The unit was initially opened October 6, 1947.

* * * *

Annual Meeting of Suppliers Association

An annual meeting was held November 6, 1947, of the Hotel & Restaurant Suppliers Association, Inc., at the Berkeley Hotel, at which meeting the final arrangements were made for the Hotel & Restaurant Suppliers Association's Annual Exhibition, which will be held at the Mount Royal Hotel, January 13 to 16, 1948.

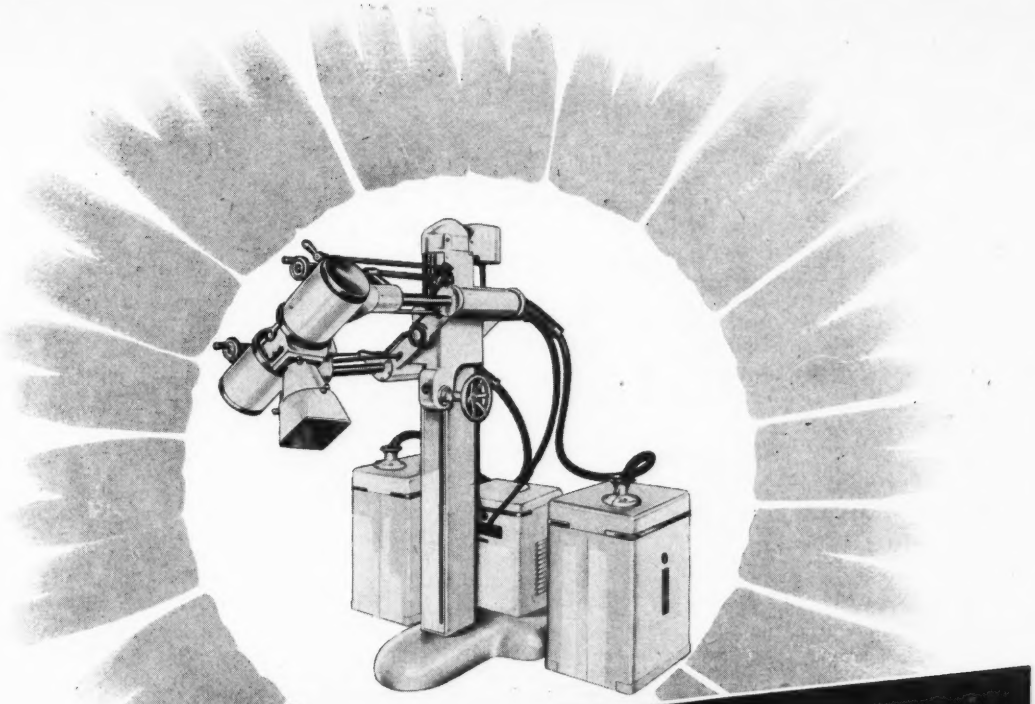
It was given to understand that this will be the largest exhibition ever held since the inception of these exhibitions 15 years ago.

* * * *

Where was "Lady in Green Perfume"?

Doctors, for all their scientific and realistic attitude, are as susceptible as other men to showmanship. So argued the manufacturer of a nationally advertised baby powder at a recent convention of the American Medical Association at Atlantic City. Three glamour maidens dressed in special costumes plugged the product for the benefit of the medicos present. The floral print dress of one girl represented the "fresher scent" of the powder. A striped dress was indicative of the product's softer texture, and the third lady in white drew attention to its whiter colour.

—*Marketing.*



The New KELEKOTE SMOOTH FINISH

● In the future, the standard finish for all Keleket x-ray equipment will be the new Kelekote Smooth Finish.

The story behind the Kelekote Finish is one of study, research and testing. But of immediate importance to you are the results of this labor.

Kelekote has a glass-smooth, hard, polished surface—no pits or wrinkles to catch dust or opaques. It is easily cleaned—will retain its lustre and brand-new appearance for years.

Neutral in tone, this new finish will harmonize perfectly with any color scheme. Kelekote is smart yet subdued—the logical finish for modern x-ray equipment.

Once again Keleket supplies the finest—first.

X-ray AND Radium INDUSTRIES LIMITED

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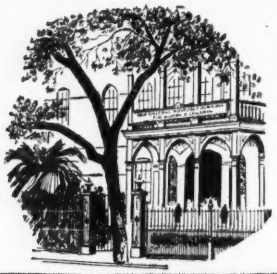

". . . these Crane Duraclay Hospital fixtures have been in constant use since 1940. They have given us excellent service and look as new today as when first installed."

From a letter received from the superintendent of a large hospital and dispensary for women and children.

Scrub-up Sinks of Crane Duraclay

Duraclay * ". . . as new today as when first installed"

That's a real tribute to Crane quality . . . particularly since these Duraclay fixtures have been on the job more than seven years.

Here's why Duraclay stays like new:

★ Duraclay is highly resistant to thermal shock —sudden changes in temperature do not crack or craze its gleaming surface.

★ It will withstand abrasion, is not affected by strong acids, and is not subject to staining.

★ Duraclay remains bright and sparkling even after years of service, and its hard glazed surface resists soiling—a damp cloth leaves it shining.

* *Duraclay exceeds the rigid tests imposed on earthenware (vitreous glazed) established in Simplified Practice Recommendation R106-41 of the National Bureau of Standards. Be sure to include Duraclay when adding to or remodeling your present facilities.*

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NATION-WIDE SERVICE THROUGH BRANCHES, WHOLESALERS and PLUMBING AND HEATING CONTRACTORS

Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, December, 1947 Vol. 24 No. 12

Integrated Planning Gives Better Service

Better Hospital Facilities *for Rural Patients*

Graham L. Davis,
Director, Hospital Division, W. K. Kellogg Foundation, and President, American Hospital Association.

THE most significant recommendation in the Michigan hospital survey is "that the general hospital be organized as the focal point through which the health services of the community are integrated".*

Integration does not mean that the board of trustees of the community hospital should have direct responsibility for and absolute control of all health activities in the area, but it does mean that the hospital should assume a much more important role in the co-ordination of health services to prevent duplication of effort and overlapping of function. The hospital in effect should be the community health centre. That is a radical departure from the traditional concept of the hospital as a place primarily for the care in bed of the acutely ill and injured.

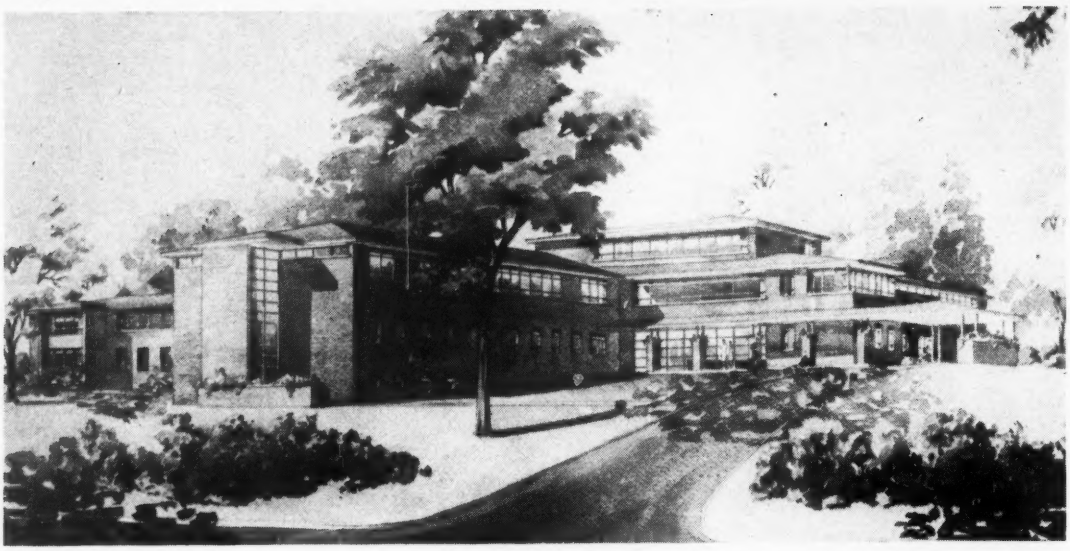
Many hospitals boast that patients suffering from *acute communicable diseases* are not admitted, but entirely too many babies die in such hospitals from diarrhoea of the newborn, one of the most violent types of contagion. The incidence of tuberculosis among hospital employees, student nurses, interns and resident physicians, is higher than in the general population because the hospital management fails to recognize the fact that contagious diseases cannot and should not be excluded. General hospitals should admit all contagious diseases that need hospital care. This would eliminate expensive hospitals for contagious diseases which are practically empty about half the time.

Graham L. Davis

Tuberculosis is becoming more and more a responsibility of the general hospital as the disease is detected earlier and treatment is much the same as for any other acute illness. The tuberculosis sanatorium isolated in the country is fast becoming obsolete. Additional beds for tuberculosis patients should be in general hospitals. In many areas this disease will be as rare as typhoid fever or smallpox in another fifteen or twenty years and the beds can be utilized for other patients if they are in a general hospital.

The state has not done so well with the problem of *mental illness* for a number of reasons. One is the age-old myth that the person with a mental illness is possessed of a devil. A stigma attaches to both him and his family and it hides him away in an insane asylum to forget about him. The human mechanism is slow to adapt itself to the stresses and strains of the atomic age. Little is being done to assist the maladjusted individual in adapting himself to this environment. His journey to the mental institution frequently

*"*Hospital Resources and Needs—The Report of the Michigan Hospital Survey," 1946, page 6. W. K. Kellogg Foundation, Battle Creek, Michigan. This was the "pilot" state survey for the Commission on Hospital Care.*



Ionia County Memorial Hospital

This building will serve as a hospital, provide doctors' offices, and include a health centre for public health activities. The health officer will be director of the hospital.

starts from the local jail. The stock solution offered by the state is more and more taxpayers' dollars to add more and more beds to overcrowded and understaffed institutions which are too large now to function efficiently.

This is an educational job of the first magnitude and the only way to reduce the incidence of mental illness is to bring the problem close to the people by placing responsibility on the health services of each community. Since the major emphasis should be on prevention and that is a primary function of public health, responsibility belongs there, but the hospital, the medical profession and all other community resources must be used to carry out an effective program.

Government assumes major responsibility for the care of the *chronically ill* (in the U.S.A.—Ed.) and it has not done so well with that problem. Many chronic illnesses could be prevented and many patients can be rehabilitated by the use of intensive diagnostic and therapeutic services found in the general hospital, including physical and occupational therapy. This problem will be dealt with effectively when every community general hospital assumes responsibility in accordance with its ability to do so.

Historically, the *health department* and the hospital have developed as separate entities. Much has been written and said about the need for co-ordination of effort to give the consumer more for his health dollar, but little has been done about it. The Commission on Hospital Care goes so far as to recommend that the health department and the hospital in the average small town and rural community be together in the same building and perhaps be organized as a single unit under direction of the county health officer. Many advantages to the community should accrue from an arrangement like this, such as a combined community-wide service, including nursing, hospital, public health and visiting.

Michigan represents a cross section of the nation. The comparatively small and thickly settled Detroit metropolitan area has approximately one-half (47 per cent) of the 6,000,000 people. The balance of the lower half of the state, a fairly prosperous farming and industrial area, has another 43 per cent. This leaves 10 per cent of the population (about 600,000) for the sparsely settled north half of the state. Great areas here are state and national forests and game preserves.

Hospital Areas

The trading area principle has been followed in defining the 71 hospital areas. Since political boundaries have little or no relation to the use of hospitals by patients, even state boundaries have been ignored in defining these areas. The basic principle followed is that the population must be large enough to support at least 50 general hospital beds for the acutely ill and injured. It is generally recognized that it takes a hospital *of at least 50 beds averaging at least 30 patients per diem* to utilize effectively the minimum number of technical and professionally trained personnel required for adequate services according to modern standards—the registered technician, record librarian and dietitian, the specially-trained obstetrical and operating room supervisors, a competent director of nurses, and others. The experience of the American College of Surgeons with its hospital approval program amply justifies that conclusion.

The minimum population needed to support a 50-bed hospital is around 15,000, but the Michigan Hospital Survey Committee decided hospital facilities of some kind must be provided within 30 miles of everybody in the state. In the upper peninsula the population thins out to the point where less than 15,000 people live within a 30 mile radius. In the St. Ignace area the population is only 8,100, and in the Manistique area, is but 10,000. For these areas the Survey Committee recommends what it calls a "community health

centre", which is a modified type of general hospital of less than 50 beds, somewhat limited in function, but operated as a branch of the nearest large hospital. In that way it can provide its community with a limited type of service of reasonably high standard and at a reasonable cost. Its administrative relationship to the larger centre makes that possible.

In recognition of the fact that it is not practical for every hospital community to be a self-contained unit so far as health services are concerned, the 51 small town and rural hospital communities are grouped into 20 regions, again on the trading area principle, around the larger centres of population. Two of these regional centres, Detroit and Ann Arbor, are designated as *teaching hospital centres* because medical schools have certain state-wide responsibilities in the field of graduate and postgraduate medical education, as well as in the education of all other types of health services personnel.

Medical Training

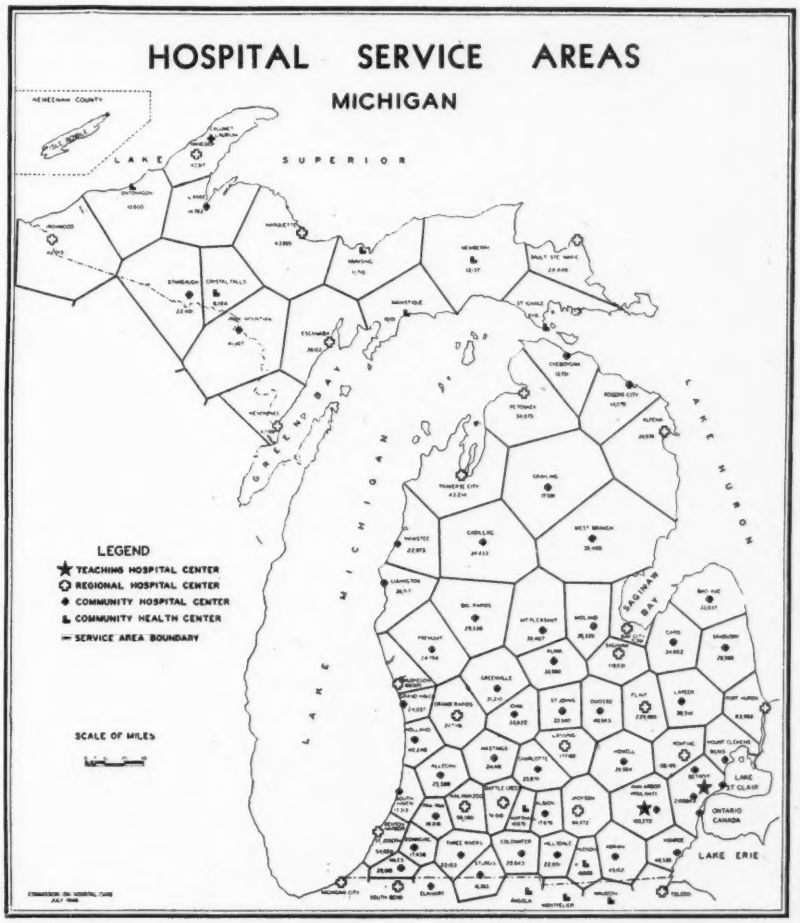
The University of Michigan is making a very substantial contribution to this program for the integration of hospital services through its decentralized graduate medical education program.* Some 20 large hospitals have worked out an arrangement with the medical school by which residents spend one year at the university during which they get basic science training. The university has in effect assumed a statewide responsibility in the field of graduate medical education. In its efforts to meet the needs of rural areas for more and better-trained general practitioners, it is introducing in some of the medium-sized hospitals a two-year combined internship and residency, six months of which the doctor spends at the university.

The ultimate objective of this decentralized intern and resident training program is to include every one of the 118 general hospital units proposed in the survey. This would mean that *every general hospital would have a resident physician at all times.* To qualify, it must be organized as a teaching unit. A hospital serves its community largely in proportion to its teaching function, both for the public and for physicians, nurses and other health services personnel. Members of the faculty at the University of Michigan visit each affiliated teaching hospital every month to conduct ward rounds and participate in staff conferences. This is also postgraduate or continuing medical education at its best.

Ultimately this should lead to closer working relationships between the medical staffs of hospitals in the regional centres and the smaller hospitals in its area. A number of these smaller hospitals now draw on the larger centres for consultants in radiology and pathology. If these smaller hospitals expect to qualify as training centres for interns and residents assigned from the university through the regional centre, they will be compelled to draw on the regional centre for consultant services in surgery, medicine, obstetrics and other specialties, and that is as it should be. It is conceivable that a region might eventually develop, through its regional health council, one common medical staff for all its hospitals with uniform staff privileges.

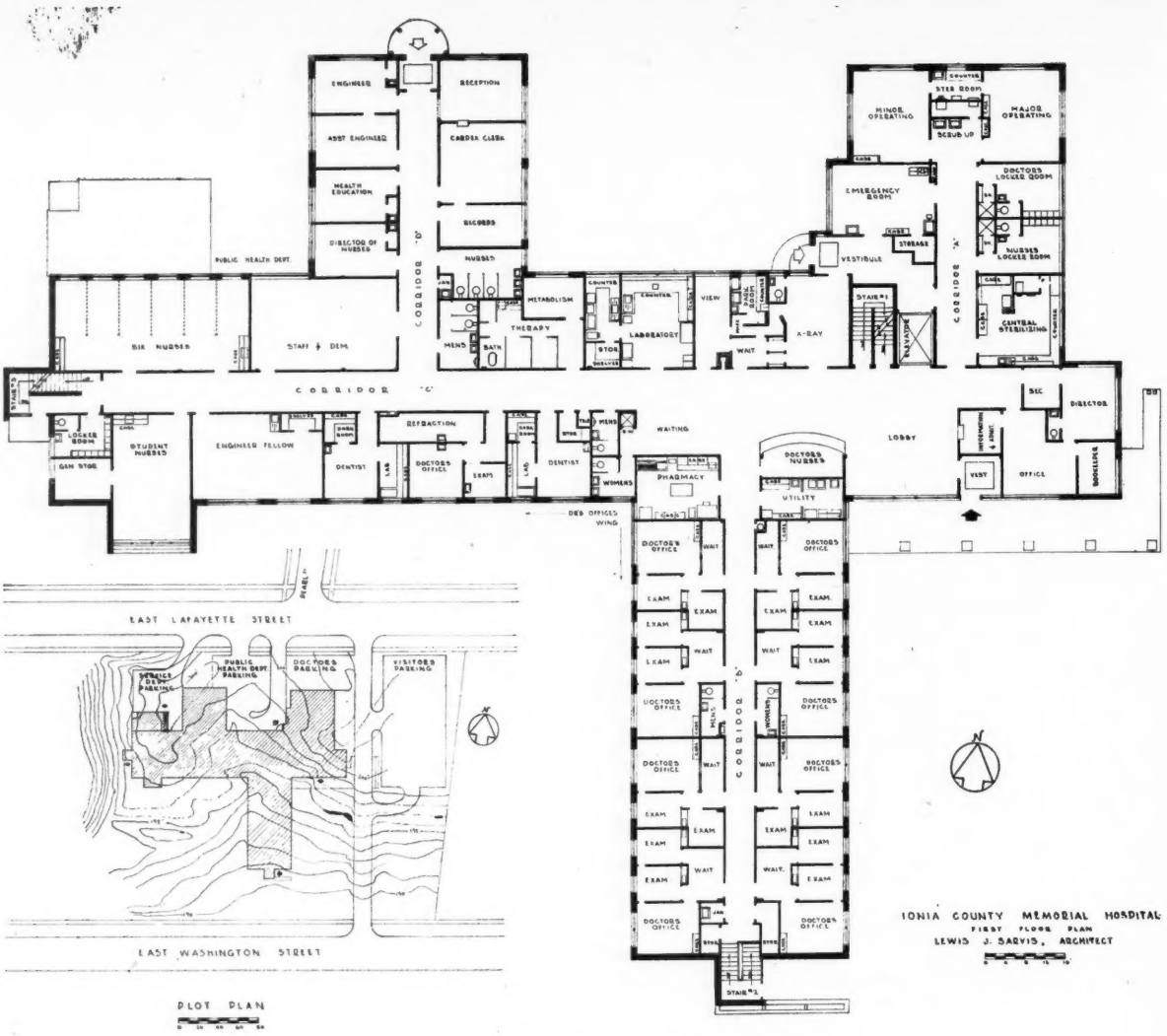
Health Centres

To carry regional integration a step further, the Michigan hospital survey recommends 181 local "health centres" or "community clinics" as branches of the nearest hospitals. These would provide an office for the public health nurse and other public health activities, simple diagnostic facilities and perhaps offices for physicians and emergency care of patients until they could be transported to a general hospital. In the



This chart indicates how the State has been divided into service areas for different types of hospitals. County lines are not followed and in the upper portion of the State coverage zones extend beyond the State boundary. Several of these areas can then be combined to permit regional integration of hospitals about the regional hospital centres.

*Wilkinson, Charles F. Jr., M.D. "Hospitals' New Role as Michigan Decentralizes." Hospitals, February, 1947.



Ionia County Memorial Hospital

First Floor Plan.

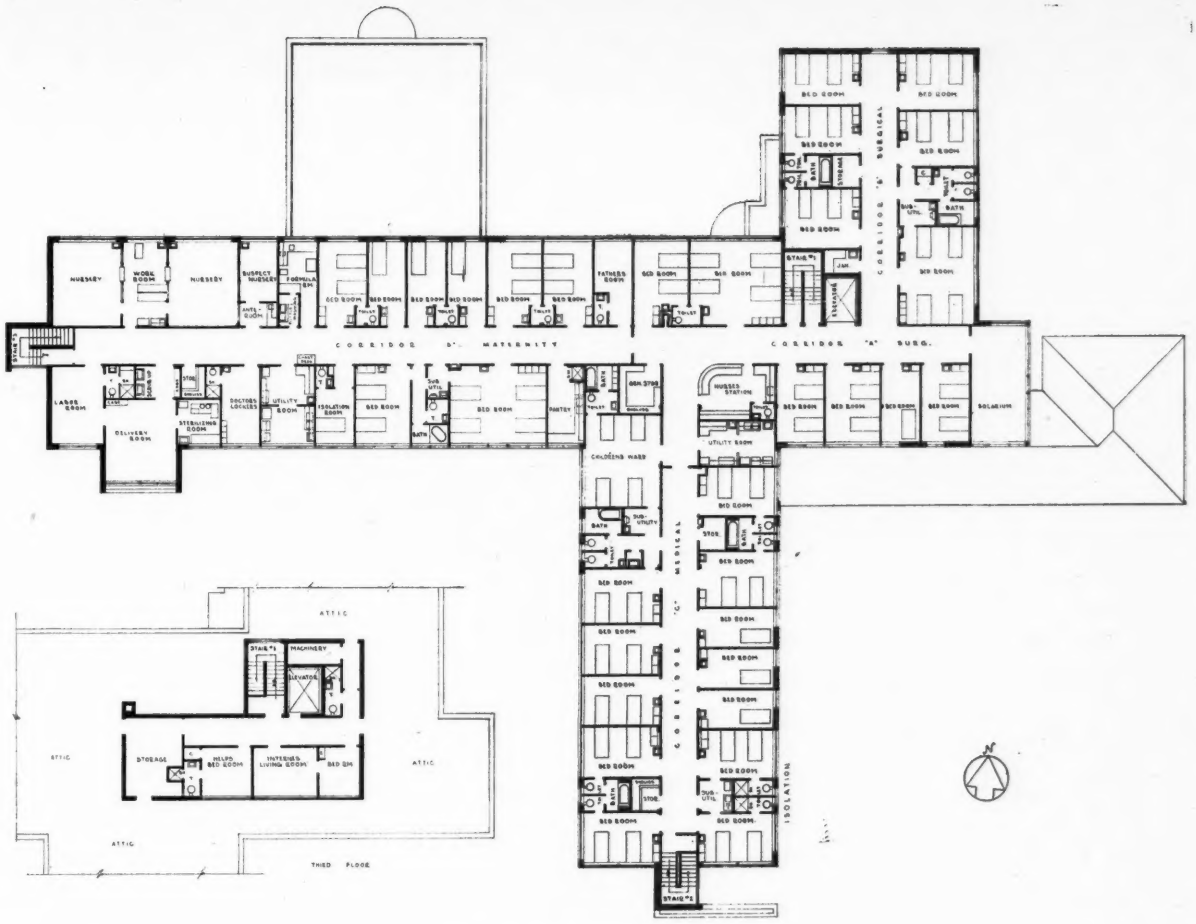
more remote areas beds might be provided for normal obstetrics and for certain types of medical cases and emergency surgery.

One major purpose of these centres is to attract the general practitioner by providing him with adequate facilities with which to work. He would have an appointment on the medical staff of the general hospital which operates the branch community clinic and would get help from its greater resources when needed. For economic reasons, to a considerable extent, physicians are disappearing from the north half of Michigan. The ratio of physicians to population is one to 10,000 or more in several places, as compared with one to 1,000 for the state as a whole.

The economic factor in this half of Michigan, which in turn accounts for its being sparsely settled, makes the health problem somewhat difficult to deal with. The tuberculosis death rate in the upper peninsula is more than double the rate in the balance of the state.

This integration must begin with the hospital as the community health centre. A number of Michigan communities are planning such integration when it becomes possible to construct hospitals again. Ionia, with a population of 6,500, is a more or less typical example. It is located 35 miles from Lansing and 30 from Grand Rapids. Its hospital area has a population of about 34,000. Its present hospital, as in 13 other rural Michigan hospital areas, is an old house, rented for the purpose, with 20 beds. The architect has planned a fine health centre, located on a high and beautifully-wooded site approximately 300 by 500 feet in size, about four blocks from the courthouse. The ground slopes away to the southwest and makes possible a basement entrance on the south side of the building at ground level. The heating plant, laundry, dietary department, locker rooms, guild room, workshop, morgue and ample storage space will be on this floor.

The first floor will provide office space for nine physicians, including an eye specialist and two dentists, administrative offices, surgery, diagnostic services and the health department. The plan is for the health officer to be director of the hospital, and the health department functions as a field training centre for public health personnel; however, the space



Ionia County Memorial Hospital

Second and Third Floor Plans.

provided for student nurses may actually be used for housing a visiting nurse service.

The 68 beds for patients, plus the delivery room, are on the second floor. Two 2-bed rooms on the medical corridor are provided with separate sterilizing facilities for the isolation of communicable diseases. These rooms will also be fitted to care temporarily for disturbed mental patients in place of the local jail. Quarters for the intern or resident physician are on the third floor. This plant is expandable in several directions and the probabilities are it will eventually contain over 100 beds, including a chronic disease unit.

Fewer Hospitals Recommended

This Michigan study was made by the Commission on Hospital Care to set a pattern for other states to follow and all the states are now making similar studies to comply with the requirements of Public Law 725, the Hospital Survey and Construction Act. A national hospital program is being developed with support from the federal government where it is most needed. The Michigan study disclosed 292 general and allied special hospitals in the state. It took courage on the part of the survey committee to recommend that this number be reduced to 118, to more economically and efficiently serve the people. Survey groups in other states are exhibiting similar courage as they plan intelligently for an integrated system of hospitals adequate to the needs of the people and they deserve all the public support they can get from all interested groups.

A large part of the credit for this national hospital program goes to the American College of Surgeons. It has always been in the vanguard of hospital progress.

C.H.C. Resolution Being Misinterpreted

Information has been received that the resolution of the Canadian Hospital Council respecting radio interference by electro-therapeutic equipment is being used to discriminate against certain makes of equipment. The resolution (page 98, November issue) was intended to seek from the government permission to operate present equipment for another five years, as has been arranged in the United States. The wording is somewhat loose in the final clause as it could be read that the Council agrees that all new equipment purchased should be crystal controlled. The intent was to agree that all new equipment should be government approved. The Council has no facilities by which to differentiate between crystal controlled or tube type apparatus.

A Sanatorium Celebrates Christmas

"And it was always said of him, that he knew how to keep Christmas well, if any man alive possessed the knowledge. May that be truly said of us, and all of us! And so, as Tiny Tim observed, God Bless Us, Every One!"

A. L. PAINE, B.A., M.D.,
Medical Superintendent,
Manitoba Sanatorium,
Ninette, Manitoba

AS Christmas is founded on tradition and established customs, there is no new way to a Merry Christmas. A strong community spirit with good will prevailing and a zest for the old customs are the requisites. At Ninette we are ideally situated. Our isolation, our size and the feeling that we are one big family gives a spontaneity that may be lacking in larger, more urban centres. Nevertheless, strict adherence to procedures now traditional in the institution are essential in giving expression to the Christmas spirit. These procedures are a heritage from Dr. David A. Stewart, first Superintendent at the Sanatorium, to whom Christmas was a very special occasion. (The "San" was truly his family and he as the father saw to it that his children had a good Christmas.) Herewith will be described the customs that developed during his years of guidance and to which we at Ninette still adhere to this day.

Let me emphasize one point which is a great factor in making Christmas a success at Ninette. Not only is going home at this time discouraged, but we actually have no Christmas leaves for either patients or staff. Rarely is there an exception and then only for serious reasons other than Christmas. This ruling is accepted for the most part without question; old timers, both staff and patients, understand its importance; newcomers comply in the hope of having the good time they hear so much about. Having the institutional family intact and at full strength is the first step towards a good Christmas.

Preparations for the festive season begin in October. Ground cedar is gathered in the Tiger Hills and laid in the root house in readiness for the making of garlands to decorate the assembly hall and dining room, menu cards for Christmas and New Year's dinner are planned and ordered from a publishing company. A Christmas present is purchased for each patient; in many cases the present is small, but needy patients receive such articles as pyjamas. A good supply of candy, nuts, fruit is also laid in to make up old fashioned Christmas stockings. About the first of December the Christmas trees are ordered, a large tree for the assembly hall and small trees for all wards and residences. Ward decorations are kept from year to year and added to as needed.

Plans are begun early in December for two distinct occasions, Christmas eve and Christmas day. A program committee must be formed for the concert on Christmas day and actually a program is also drafted for a New Year's concert at the same time. The committee is composed of both staff members and patients. One patient representative co-ordinates patient activity and sees that each group has its act in good shape and ready in time. The medical representative acts as chairman for the committee and is directly responsible

Perhaps the spirit of Christmas is better expressed in Dickens' "A Christmas Carol" than in any other English writing. Each spends his Christmas according to his habit, with the roots lying deep in childhood. Yet a guiding theme runs through all Christmas activity, for no one can have a satisfying Christmas by himself. The Christmas spirit is essentially one of giving and of sharing the good things of body and spirit. The ancient call of "Goodwill toward men" rings down the centuries carrying with it a tradition and a ritual which, when fulfilled, satisfies a deep-felt need and gives all who participate a "Merry Christmas".

—A.L.P.

All Set for Christmas Dinner.

to the Medical Superintendent who is consulted in the final arrangement of the program.

Decorating begins two days before Christmas and by the afternoon of Christmas eve all wards, assembly hall and dining room are in festive attire. Christmas Eve is celebrated in a manner which we believe is peculiar to Ninette. Staff members assemble at 6:00 p.m. to sing Christmas carols, which have been practised for several evenings in advance, led by a choir master and augmented by violins and horns played by staff and ambulant patients. This group, some 30 to 40 strong, pass from ward to ward singing carol request numbers for the patients assembled in groups to receive them. Before leaving each ward the carollers chant in unison "We all wish you all a very Merry Christmas".

Close on the heels of the carol group comes Santa Claus, accompanied by Mrs. Santa Claus and two pretty girls dressed as fairies, heralded by the ringing of sleigh bells. Santa, with their aid, distributes the various presents from each ward Christmas tree.

When all non-ambulant wards have been thus covered the carol group enter the assembly hall where staff, staff families and patients, are gathered before the large Christmas tree. Several carols are sung with everyone joining in. Soon Santa arrives and the distribution of presents begins. Here again an old Ninette custom is still followed. This consists in the giving of fake presents to various local characters whose position merits attention. The routine is as follows: about a week before Christmas several old timers and some of the medical staff get their heads together and talk over incidents during the year by which various people have left themselves exposed to fun poking. With this data at hand ingenious presents, some of them monstrosities, are constructed in the carpenter shop. Santa has these objects on hand at the Christmas tree and presents them along with an extravagant account of the incident being illustrated. This results in considerable chagrin for the recipient and much merriment on the part of the audience. The Superintendent, the Matron and other notables are always honoured with one of these doubtful presents and, indeed, although occasionally a tender spot is struck, this is taken as a rough gesture of esteem more prized than the decorous respect usually accorded at other times.

A Christmas tree is never quite the same without children. We have no small patients at Ninette, but the children of the Sanatorium families turn out in full force and their numbers are swelled by a good many young ones from the village. Santa always has a present for each child, even though presents from other sources may be lacking, which is seldom. Each child also gets a large Christmas stocking filled with candies, nuts and fruit. After the presents are all given out the patients retire to rest up for the big day to come.

Christmas day begins officially at 11.00 a.m. when the entire medical staff, the matron and dietitian set off in a group to make the rounds of infirmary and pavilion wards. Everyone shakes hands with each patient and wishes him a Merry Christmas. Some may frown on this custom in a sanatorium, but hands can be well washed afterwards and it expresses the feeling of goodwill and well-wishing better than a more impersonal approach. This group also visits the kitchens and exchanges greetings with all staff members they may chance to meet.

Christmas dinner on infirmary and observation wards is held at noon and a good many of these patients are allowed to dress and dine at long tables set in the larger wards. The visiting medical group usually run into them while at table and the merry spirit of the occasion is enhanced by the spectacle of many who have grown too fat for their clothes.

Christmas afternoon is a special visiting occasion for patients, all those on ambulant and observation routine being allowed to frequent the

(Continued on page 78)

Registration was beyond expectations, some 250 registrants coming from the four western provinces.

Western Institute for Administrators Draws Record Attendance

THE second Institute for Hospital Administrators and Trustees of Western Canada, held in Edmonton during the week of October 20, set a real mark for succeeding ones to emulate. The attendance was quite a record for Institutes, over two hundred exclusive of teaching staff being registered.

A particularly fine program was arranged. Some forty different speakers contributed addresses, including a number from a distance, such as Dr. MacEachern and Kenneth Williamson of Chicago; D. M. Cox, Dr. Harry Coppinger, Dr. C. R. Donovan and Dr. O. C. Trainor of Winnipeg; Rev. Father Bertrand of Montreal; Miss Elinor Palliser, Percy Ward and George Masters of Vancouver; A. J. Swanson of Toronto and the Secretary of the Canadian Hospital Council.

A feature of the program was the number of topics which were related to the smaller hospital. This was much appreciated by the registrants who came from small hospitals. They found the addresses by Dr. Morley Young of Lamont, Miss Marjorie Gordon of Lacombe, Miss Jean Clark of the Alberta Public Health Nursing Branch, Dr. A. Somerville, the Alberta medical inspector, Vernon Pearson, mechanical

Dr. A. C. McGugan, Chairman of the Institute, and Mr. Leonard Wilson, President of the host Association.

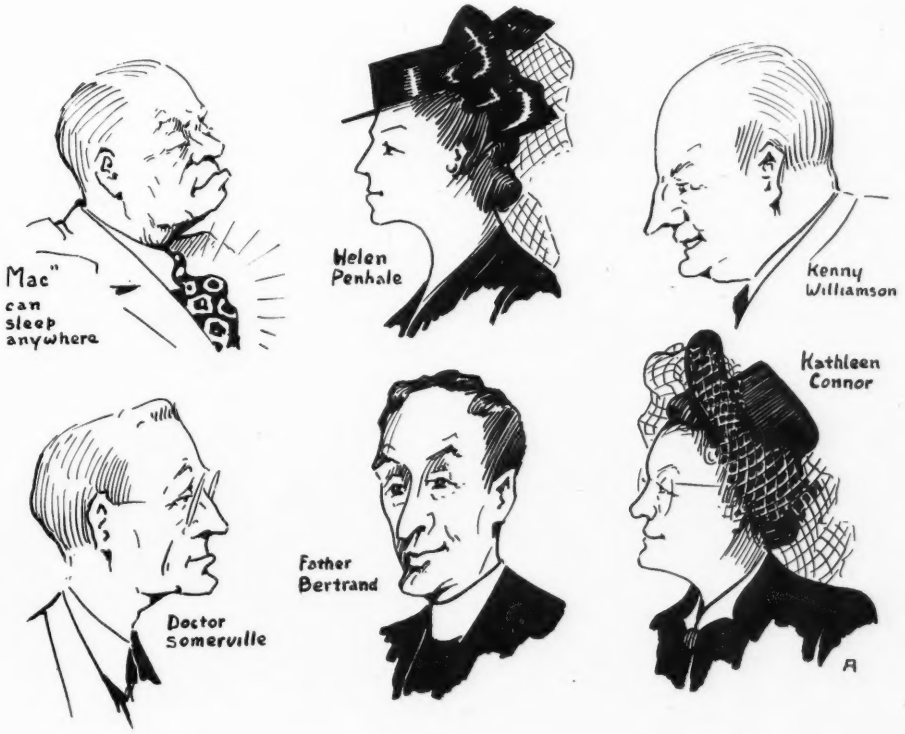
At the "Stump the Experts" Evening

Here we have the "Faculty" of the Institute—most of them, anyway. *Back Row,* Leonard Wilson, Murray Ross, Nelles V. Buchanan, Dr. Morley Young, W. C. Ryan, Percy Ward, L. R. Adshead, Dr. A. Somerville, E. E. Maxwell, Rev. H. L. Bertrand, Dr. A. C. McGugan; *Middle Row,* Geo. Masters, Miss E. K. Connor, A. J. Swanson, Miss Jean Ferguson, Miss Jean Clark, Dr. M. C. Adamson, Mrs. J. Porteous, Dr. Gordon E. Wride, Miss Marjorie Gordon, Leonard Goudy, John McGilp; *Front Row,* Dr. Harvey Agnew (directing quiz session), Miss Elinor E. Palliser, Donald M. Cox, Miss Helen Penhale, Dr. M. T. MacEachern, Dr. A. F. Anderson, Dr. A. E. Archer, Kenneth Williamson.

engineer, Dr. Gordon Wride of the Saskatchewan Department of Health, and E. E. Maxwell, Alberta supervisor of municipal hospitals, particularly helpful.

The hospital tours and demonstrations were well arranged. Registrants were so grouped and routed that everyone had an opportunity to take full advantage of what was offered. Tours included not only the hospitals but also the Red Cross transfusion depot where blood is prepared for use throughout the province.

Speakers at the well-attended din-



ner were Mr. Arthur J. Swanson, President of the Canadian Hospital Council, whose advice "Let's Tell the World" would go far to correct the many misunderstandings of the public respecting hospital costs and difficulties, and Dr. M. T. MacEachern who touched on twenty-three features that will characterize the hospital situation of the future. Incidentally, Dr. MacEachern's garish taste in neckwear, which drew platform comment early in the week, proved so attractive to the ladies that a veritable rash of torrid ties broke out among the men.

The opening was most impressive —"O Canada" being led by a choir of nurses and the Trocadero orchestra. By means of a battery of eight or ten microphones scattered throughout the hall, everything said was recorded with the compliments of the Dictaphone corporation and, through the courtesy of the Gestetner people and volunteers from the hospital office staffs, each day's proceedings was given to each registrant the next morning. This service was much appreciated.

Much credit is due the local Committee for the very fine arrangements planned and completed in detail. In using the *Trocadero* (a large night club not unlike the *Normandie Roof*), the Committee assumed added financial obligation, but met these expenses with exhibits and program advertising. To mention only a few of those who put so much work into the details of planning, we note, Dr. McGugan, and Messrs. Adshead, Ross, Hollingshead, Monoghan, Wilson, Heathcote, Gallant, Robarts, Beaton and McGuire.

Although no definite arrangement has been made as yet, it seemed probable, at a meeting of the Co-ordinating Committee of the four western provinces, that the Institute will be held next year at the Coast. It was agreed that the original policy—to hold an institute in the West each year and to rotate among the four western provinces—would be maintained. More definite announcement will be made later.

Ontario Conference, C.H.A. Holds Meeting in Toronto

The fourteenth annual convention of the Ontario Conference, Catholic Hospital Association, was held at St. Michael's Hospital, Toronto, on November 5th and 6th.

Sister Marie Alban of Ottawa presided and her opening address covered many important problems respecting hospital administration and nursing education.

Among the speakers were: Rev. John J. Flanagan, who brought greetings from the Catholic Hospital Association of the United States and Canada; Rev. Hector L. Bertrand, who spoke on behalf of the Catholic Hospital Council of Canada; Rev. John G. Fullerton; the Hon. Russell T. Kelley, Minister of Health; Dr. Allan Noble and Dr. Ronald C. Burr.

Officers for the coming year are:

Pres.: **Sister Mary Kathleen, Toronto.**

1st Vice-pres: **Sister Ursula, Hamilton.**

2nd Vice-pres.: **Sister Gonzaga, North Bay.**

3rd Vice-pres.: **Sister Eunice, London.**

Sec.-Treas.: **Sister Murphy, Kingston.**

Executive Members: **Sr. Marie Alban, Ottawa; Sr. M. Elizabeth, London; Sr. Byrnes, Kingston; Sr. Vincentia, Toronto; Sr. Mary Alice, North Bay.**

How to Obtain the Best Possible Return in Goods for Dollars Expended

Hospital Purchasing

L. R. ADSHEAD,
Treasurer,
University of Alberta Hospital,
Edmonton.

THE purchasing department is a very important part of the hospital organization. It is the function of this department to see that an adequate stock is maintained in the hospital of all supplies and goods for the treatment and care of patients. Of the total expenditure of the modern hospital, approximately 55 per cent is spent on salaries, 5 per cent on services and 40 per cent for purchased supplies. This means that the purchasing agent spends $40.00 out of every $100.00 of hospital expenditure. It is, therefore, very essential that these funds be expended in a manner to assure the best return in goods.

Whether the purchasing is done by the nursing supervisor or administrator in the small hospital or a full time purchasing agent in a large hospital, it is essential that they should be constantly informed regarding new products, equipment and market trends. Regular reading of hospital and trade journals should be a must for the purchasing agent.

Adequate Records Essential

One of the first essentials in efficient purchasing is the maintenance of adequate records. Wherever possible a *perpetual inventory* should be maintained. For the information of some who may not be familiar with this term, it is simply a record of each commodity showing the quantity on hand, adding thereto purchases and deducting therefrom the supplies used from day to day. For example, you have a card or ledger sheet for bolts of gauze with, say, 30 on hand in the store room. You purchase 100 and this is added, making a total on hand of 130. You then issue 5 for use in the operating room and this reduces your stock to 125. A similar card or ledger sheet is used for each commodity used in the hospital.

This record may be expanded to give you a wide variety of information:

1. A list of firms from which goods are obtainable;

2. A record from month to month and year to year of the amounts purchased together with the rise and fall (in recent years mostly rise) in the unit price;

3. A record of all orders placed showing quantities not yet delivered on outstanding orders;

4. By a system of distribution, charging all departments with supplies used, you can keep an accurate record of the use of supplies. You may even break this down further and charge out supplies to various nursing units and thereby ascertain which sections of your hospital are careful in the use of supplies and which are extravagant. It is just as essential to keep a careful check on the use or waste of supplies as it is to keep a careful check on the cash handled by the cashier.

If the hospital is large enough and it is possible to maintain a purchasing office separate from the stores department, this is advisable. The perpetual inventory which should be kept in the purchasing agent's office for a quick reference as to quantity on hand is then not available to the stores clerks for ascertaining what should be on the shelves and adjusting their physical stock accordingly. An adequate perpetual inventory is the key to efficient and economical purchasing.

Centralized Purchasing

There has been in the past a considerable difference of opinion among hospital administrators as to the merits and demerits of centralized purchasing. I think that it is the consensus now that the centralized system, with some minor modifications, is the best. This is the system in operation in the University Hospital. All medical supplies, cleaning supplies, printing and stationery, are bought solely by the purchasing agent. Other supplies are obtained by the purchasing agent in consultation with department heads. One exception to this is the pharmacy where orders are cleared through the purchasing agent's office for record purposes only. Pharmaceuticals definitely should be purchased by a specially trained person. This is one department where, because of the small quantities used in the compounding of prescriptions, it is not practicable to maintain a complete perpetual inventory. On pharmaceuticals we maintain only a record of possible supply houses, purchase orders placed and quantities of goods received. The only time we have an accurate record as to stock on hand

From an address at the Edmonton Institute for Hospital Administrators.

is at the end of the fiscal year when a physical inventory is taken.

What Quantities?

There are a number of factors to take into consideration when determining the quantities of an article to be purchased. However, there may be others which, because of local conditions, might be of more importance in some hospitals.

1. *Are there sufficient funds to finance the purchase?*

2. *Is there adequate storage space to store the article properly?* Quantities of oil or inflammables require proper fire proof storage, preferably below ground in a concrete room where they will be kept reasonably cool. A good root house is required for storage of vegetables for any length of time. A store room where goods can be kept in orderly fashion and where they are easily accessible for checking is an essential.

3. *Will the goods purchased deteriorate?* This must be considered when buying rubber gloves and other rubber products. They will deteriorate rapidly if not kept in cool storage.

4. *Will the goods become obsolete?* This is a factor to consider when buying pharmaceuticals.

5. *Spoilage* is an important factor in the purchase of fruits and vegetables.

Generally speaking, however, medical and cleaning supplies, printing and stationery, paint and linens, remain fairly stable and in normal times could, if store room space and funds are available, be purchased on a yearly quotation basis, thus obtaining the maximum discount and effecting substantial savings.

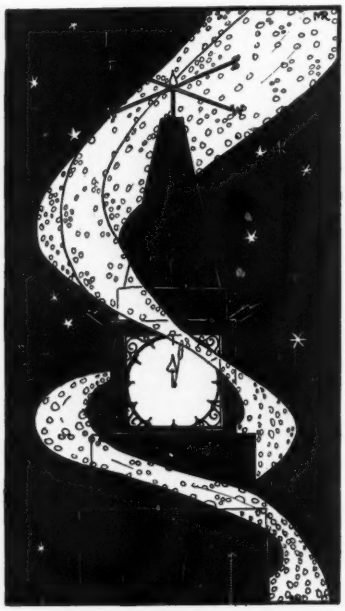
An established buying policy and co-operation of department heads are essential. Do not instruct your purchasing agent that he must always buy at the cheapest price. For example, some wards are to be painted and the purchasing agent, carrying out established policy, purchases the cheapest paint. The painter applies this and in two months it peels off. Whose fault is it? Not the painter's, he only applied the paint he was given. Not the purchasing agent's, he only bought the cheapest he could get. Specifications should be worked out by the purchasing agent in co-operation with the department head.

Discounts and Sales Tax

The purchasing agent should be responsible for seeing that the hospital is receiving full credit for quantity discounts and tax exemptions, et cetera. And here may I say a word about sales tax. As you all know, through the good offices of Dr. Agnew and the Canadian Hospital Council, some years ago hospitals were given exemption from the 8 per cent sales tax on all purchases. All that is required to obtain this exemption is to give the firm from whom you purchase your goods a certificate with each purchase order stating that the goods are not for re-sale but are for the sole use of your hospital. In discussing this with some of the smaller hospitals who purchase a considerable amount of goods from the local retail stores, I find they are not getting this exemption. There is no reason why they cannot, as the retailer can obtain his rebate by submitting a claim statement to the Customs and Excise department of the Dominion Government the same as a wholesaler. If the retailer does not know the amount of tax paid on the goods sold to your hospital, the regulations provide that he may obtain a minimum rebate of 4 per cent on his retail selling price. I have verified this with the Customs and Excise Division.

There is just one thing you should watch.

Insulin or liver extract are specifically exempted under the Act but if you are reselling other pharmaceuticals at more than 10 per cent over cost, it is necessary to keep a record of these and pay the collector of Customs and Excise 7.41 per cent on the selling price of prescriptions that are compounded in your pharmacy. On prescriptions that are only re-bottled or re-packaged in your pharmacy, such as aspirins or vitamin pills, you are required to pay only 8 per cent of your cost. The reason for this difference is that in compounding a prescription you are classed as a manufacturer and must pay as a manufacturer on your selling price.



In the purchasing of hospital equipment, *service* is a very important factor. A machine out of commission for a few days or weeks may cost the hospital far more than the original purchase price. Always check the reliability of the firm from whom you purchase. Have they a branch office or a service agent who can be called in on short notice, or are they a firm with an office only in Eastern Canada or the United States, and will it be necessary to send the machine back to the factory for even minor repairs? It is wise to consider these questions before purchasing any piece of equipment.

In *The Reader's Digest* there appeared the story of a woman who said she had nine children and another one on the way. A friend said to her, "Why don't you stop having children?" She replied, "It's the only way I can figure to stop spoiling the youngest." So this is the only way I can figure to conclude this paper. Definitely the rising costs demand that our purchasing be done in such a manner as to obtain the most in goods for the cash expended and that a system of distribution be established to control the use and the waste of supplies as these supplies represent cash. If it has not already been done, it is essential for efficient operation that a centralized system of purchasing be established with proper records controlling both the purchase and the distribution of supplies.

Ideals

Ideals are like stars; you will not succeed in touching them with your hands, but like the seafaring man on the desert of waters, you choose them as your guides, and, following them, you reach your destiny.

—Carl Schurz

The Canadian Red Cross Hospital in Britain

C. E. A. Bedwell,
"Londoner"
London, England.

THE Canadian Red Cross Hospital, so generously given to the English Ministry of Health as a memorial of the work of the Canadian Red Cross in Great Britain, stands in one of the most beautiful parts of the country on the borders of Hertfordshire. During the five years of active service 25,068 patients of all ranks and branches of the Canadian and allied forces received treatment.

The hospital is on land originally forming part of the Cliveden estate given by Lord Astor to the National Trust to promote fellowship and goodwill among the English speaking peoples. It constitutes the largest of the gifts made to the Trust as its object is the noblest. The National Trust is not a State corporation, but is a body incorporated by special act of Parliament to hold property and preserve the beauties of the countryside. It is doing a wonderful work and has been particularly fortunate in the neighbourhood of the hospital. Just to the north of it, for example, is the village of West Wycombe which has a unique interest and is the property of the Trust. It has been acquired as a typical example of an old country village, in which some of the buildings date from the fifteenth century and are being preserved as far as possible in their original condition.

The attractive repose of the countryside away from any centres of population has the disadvantage for the patients, especially the out-patients, and their visitors, that the hospital is not readily accessible. The means of public transport, however, is being improved and supplemented by a service provided by the hospital.

Between the occupation by the Red Cross and the re-establishment as a hospital there was an interval, so that it has been necessary to start afresh, though a large portion of the equipment was generously made available. The new governing body is a combination of a variety of interests giving to it a national character imbued with the spirit of the voluntary hospitals. The hospital is singularly fortunate in its Committee of Management. The representative of the Nuffield Hospitals Trust, Mr. A. Noel Mobbs, is the chairman. The Bucks County Council has five representatives, as the residents of the county are particularly in need of its services. The Berks County Council has two representatives, and a Divisional Hospitals Council of the two counties has two representatives, of whom one is Sir Owen Morshead, the King's Librarian. As chairman of Windsor Hospital he is specially concerned with co-ordinating the activities of the two hospitals. Dr. T. F. Cotton represents the Canadian Red Cross. Among other bodies represented are the Universities of Oxford and London, the Royal Colleges of Physicians and Surgeons and the Ministry of Health. One of the two representatives from the Ministry of Health is the Chief Medical Officer, Sir Wilson Jamieson. The medical staff embodies an equally wide representation. The director of the department of medicine is Dr. George Hadley of the Middlesex Hospital. His opposite number in surgery is Mr. Ralph Marnham of St. George's Hospital. The senior obstetrician and gynaecologist is Mr. David Maxwell who is a well known

consultant in the locality. Other departments have specialists appointed with equal care. Under the terms of the Trust the particular department is for the promotion and advancement of all forms of research in cardiac rheumatism in childhood. This involves a piece of team work between Dr. R. C. Lightwood, the paediatrician from Great Ormonde Street Children's Hospital, and Dr. Paul Wood, the cardiologist of the National Heart Hospital.

The design of the building follows in the main the type which was made available for the Forces. It consists of a number of single storey blocks of standard dimensions with the exception of a two-storey block for the administration with an impressive entrance. While in use by the Red Cross during the war there were fifteen general wards, each with thirty-seven beds, together with four smaller wards each with twelve beds, and sixteen private rooms. This, however, does not give the full measure of the accommodation, because at times of stress, for example after Dunkirk, the demands required provision to be made for a far greater number of beds. It is in this connection that the main difference is noticeable under the new conditions, as provision is now available for only about four hundred and fifty patients. So far only about half that number is in actual occupation. The primary need of the area was for maternity patients necessitating the allocation of space for labour room, et cetera, which had not been previously available.

The hospital was opened on January 1st. Owing to the marked increase in the birth rate the preference was given to maternity patients. The first was admitted on January 2nd and the first baby was born on the 3rd. In the general lying-in ward for the unit there are two eight-bed wards and six single rooms. The latter are used for patients needing extra quiet—following operations—or for patients needing medical care due to conditions arising from pregnancy. Provision is made for emergency cases in an eight-bed ward with two single rooms. By this arrangement patients who may be a possible source of septic conditions are kept separate from the booked cases, whose history is known to the obstetricians.

The nursery has thirty-four cots. In it the babies spend the night and have their baths. The aim, however, is for them to be at the bedside of the mothers during the day, so that the natural association may be maintained as far as possible, preparatory to the time when the mother leaves hospital and has the full responsibility for the care of her child. Attached to the nursery are two small rooms equipped for premature babies. Other additional accommodation which has been necessary includes provision for two isolation beds and a classroom for the use of pupil midwives. It is hoped that the latter will be used by midwives working in the adjoining counties for post-graduate lectures and reunions. The classroom will have a library and a small museum and is so designed that it will be convenient for showing films. Another unit to be added for the completeness of the department will make provision for six premature babies. Attached to this will be an eight-bed ward for antenatal patients.

The fathers have not been forgotten, as there is a waiting room where they can spend the night. The official description naively adds—"there is a telephone installed for their use".

While the immediate need of the neighbourhood necessitated that the first allocation should be to maternity patients, arrangements proceeded for the establishment of the unit for children with cardiac rheumatism. Approximately half the existing accommodation is to be devoted to these children in fulfilment of the understanding with the Canadian authorities that their gift should make a contribution to some need of national importance. An important structural alteration has been necessary by the removal of the south wall in order to open up the wards, so that the children may spend practically the whole of the time in the open air. Experience has shown this to be beneficial, even in the English climate, and it was a point to which importance was attached by such an eminent authority in the care of children as the late Sir Henry Gauvain.

Rheumatism provides a leading example of the connection between disease and social conditions. "Most authorities," writes Dr. Kershaw in his illuminating book, *An Approach to Social Medicine*, "accept the view that there is some transmissible causal organism of this disease, but none has yet identified it. In addition, however, other influences are important in its causation. There is reason to believe that susceptibility to it may be hereditary. We know that its development is favoured by certain climatic and other environmental factors. It is protean in form and we know comparatively little about the relation of its forms to one another. And this disease, whose greatest ally is our ignorance of its cause and cure was, at least until the outbreak of war, the greatest single cause of invalidism in industry in Britain. Its importance to the sufferer is interestingly linked with economic circumstances." Clearly there is a vast field for research in which a social service department may have a valuable contribution to make to the investigations of the medical staff. If the patients are drawn from different parts of the country the ramifications of their inquiries may carry the influence of the Red Cross Hospital into unexpected places. It is anticipated that the patients will fall into two groups (1) long term, and (2) short stay. No doubt the former, constituting the majority, will provide the principal basis for research. For them it will be necessary to engage educational staff in collaboration with the education authorities.

The development of this unit is dependent, as so much hospital work is at the present time, upon the provision of staff. In the Canadian Hospital there is a special difficulty as a considerable amount of accommodation formerly in use is not now available. Their large male staff accepted conditions in time of war which are unsuitable for civilian hospitals and student nurses. In spite of the restrictions of various kinds upon the erection of buildings of this character, the authorities are showing great sympathy in a practical form with the needs of the hospital.

The position of the hospital within the National Health Service Act is of some interest. It will be one of several which have received attention in the formation of the regions. At first it was thought that they would be in a region cen-

(Concluded on opposite page)

The Spirit of Surgery

THE spirit of surgery endeavours to build up surgeons of character fitted to carry in a worthy manner the torch of science bequeathed by their predecessors. It seeks to inculcate in them a surgical conscience which while recognizing defects in technique is more concerned with the morals that guide them, that intangible something which leads them to apply invariably the Golden Rule, "Do unto others as you would have them do unto you". It seeks to develop the highest ideals; to promote standards of professional righteousness; to advance in efficiency in mitigating human suffering and in prolonging human life; to inspire the unfolding of character which stamps one as a bedrock of the profession and without which attainment is negligible. It encourages reverence for tradition. It instils inspiration from the ideals and achievements of the past as well as a realization of their value as a guide to our present and future conduct. It urges progress in the acquisition of scientific knowledge as well as a mastery of the art of surgery.

The science of surgery may be readily defined, while the art is more elusive. The difference between them may be brought out by comparisons culled from the literature. "Art knows little of its birth: science knows its birth, registers it and its after history. Art is founded on experience: science is antecedent to experience. Art invents: science discovers. Art comes out of darkness, goes on its own feet, can go anywhere across the country, and hunts more by scent than sight: science goes upon wheels but must have a road or rail. Art furnishes a set of directions which vary with the artist and the task: science furnishes a body of connected facts which are the same for all people, circumstances and occasions. Art is often life rented and dies with its possessor: science is transmissible. Art is completely personal and deals with actual problems of human conduct from the economic, psychological and legal, as well as medical, points of view: science is entirely impersonal, proceeds in an orderly manner toward the establishment of a cause and, if possible, to a remedy for disease. Art shows the how and cares less for the why: science says little as to the how but much as to the why. Art is often the strong blind man on whose shoulder the lame and the seeing man is crossing the river. Wisdom is the vital union of art and science: wisdom is the body animated by the soul and the will knowing what to do and how to do it."

In treating the sick these two essential components, science and art, must be kept balanced if we are to realize as a profession our greatest usefulness. No amount of scientific efficiency can take the place of sympathy, pity, and cheerful hope in the dark hours of sickness and sorrow that inevitably come to all. President Eliott of Harvard said: "In these intangible things are found the durable satisfactions of life: fame dies and honors perish, but loving kindness is immortal." In its broader and more humanitarian sense medicine is an altruistic profession. This quality plays an important part in many professional activities. It controls the various relations of the surgeon to society. It determines his responsibility to his patients. There is something of value in the training and equipment of the surgeon which science does not supply. No one whose interests are purely scientific to the exclusion of the humanitarian should engage in private practice: his place is in a research institute. No one whose interests are purely commercial should be in medicine: his place is in business.

The profession of surgery comprises a democracy of intelligence knowing the boundary neither of creed nor of nation. The task of treating the spirit of surgery and the advance and progress emanating therefrom cannot be accomplished on a nationalistic basis since surgery, like every other science, is cosmopolitan in its aims and international in its influences.

Its scientific advance and its technical victories are the wonder not only of the profession but of the lay world as well, giving evidence that its spirit is ambitious and progressive, resourceful and daring. We cannot know what effects upon it will follow the stupendous discoveries consequent upon the release of nuclear energy but we know that it will rise to the challenge. A prominent scientist declares that the beginning of the research use of radio-active isotopes made in atomic energy piles may be judged in subsequent years to be the most important event of 1946—that the secrets of photo-synthesis, cancer, and even life itself may be discovered by such investigations. The work already accomplished reveals a definite relation between the advance of nuclear science and the advance of surgery with the future holding seemingly almost limitless possibilities.

—*Irvin Abell, M.D., F.A.C.S., Louisville, Retiring President, American College of Surgeons.*

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tred on Oxford but it was finally decided that their natural association is with the metropolis, so they have been placed in one of the metropolitan regions, which derive their conception from sectors constituted during the war. As regards finance the Ministry of Health is responsible and, after the appointed day for the Act to come into operation (which is expected to be July 1st, 1948) practically the whole cost will fall on the national exchequer, though there will be opportunity for voluntary contributions to provide additional amenities. There may also be fields for extended research which do not fall strictly within the health services. There is no doubt that the Canadian Red Cross have provided a great opportunity, which, if used to the full, may save the rising generation from a great deal of disablement and unhappiness. It may also make a notable contribution to the health of the nation.

Obiter Dicta

Ontario Association Launches Hospital Pension Plan

THE widespread prevalence of pension plans among the better organized industries, financial companies and educational institutions, is making the development of pension plans in the hospital field not only desirable, but almost essential. Certainly it is in keeping with the present day concept of social security. Quite a number of hospitals now have their own pension plans. The pension committee of the Canadian Hospital Council made a preliminary report at the Winnipeg meeting, a report favouring the adoption of pensions, the utilization of the Government Annuity plan as a basis and indicating, though not with finality, that the hospitals might find it desirable to work out individual plans. The Committee thought there was need for a special cash withdrawal privilege to meet the need of those female employees who do not contemplate remaining in the service until retirement date. This is not available under the Government Annuity plan.

In this connection it is of interest that the Ontario Hospital Association has offered to undertake the administrative work involved in setting up a pension plan for hospital employees. The plan proposed will take full advantage of the annuities issued by the Canadian Government inasmuch as these are considered to give the highest degree of safety at the lowest cost obtainable. It calls for a contribution from the employee of 5 per cent of his, or her, salary, including the value of board, lodging and other perquisites if provided, and for a similar contribution of 5 per cent from the hospital.

The recognition of past services is one of the major problems in setting up a pension plan. In order to recognize these years of past services, it is proposed that the hospital set up a contingent liability on the basis of one per cent of the salary for each year of past service and based on the salary in effect during the year previous to the coming into operation of the plan. It is estimated that to set up such a reserve for pensions to cover past service of all participating employees would cost the average hospital approximately 25 per cent of its present total payroll of the said employees. If, however, contributions for past services are limited to a period of years, going back no further than age thirty of any employee, the contingent liability would be considerably reduced. Where funds are not immediately available to establish this reserve, arrangements can be made whereby the amount can be amortized over a period of ten, fifteen or twenty years.

The Association will act as the intermediary between the hospitals and the Annuities Branch, receiving the lump payments from each hospital and assisting to maintain records of employees' services.

This action is a long forward step in service for a hospital association. The development should be of tremendous help, not only to hospitals in Ontario, but indirectly to hospitals elsewhere which have been seeking leads which would indicate a good approach to this matter of pensions for employees.

Import Restrictions and Hospitals

THE effect on hospitals of the two trade and import announcements made on the same day in November is not entirely clear at the time of writing. On the one hand, we received the general terms of the new tariff agreement by which a number of foreign-produced articles would be subject to a lower import duty and by which other countries, such as the United States, would lower their tariff and quota restrictions against Canadian export goods, cattle, wheat, et cetera. This good news was quickly overshadowed by the blunt statement of the Finance Minister that our international credit is fast dwindling, that in ten and one-half months it had fallen by more than seven hundred millions of dollars, that, as a nation, we are living beyond our income and that drastic corrective measures could be delayed no longer. The treatment prescribed is unpleasant but should be effective.

Hospitals will be affected, but to what extent remains to be seen. Much imported equipment will be very hard to obtain unless special exemptions are created for hospitals. Articles which cannot be imported include fresh fruit, other than citrus fruits (on a quota basis), and bananas; all fresh vegetables, except potatoes and onions

(on a quota basis); most canned goods; mineral oil and refined petrolatum jellies; baths, basins and sinks of iron or steel; typewriters, dictating machines and adding machines; most electrical appliances; radios, electric razors; projectors and sound equipment; cameras, other than for professional use (this might not affect hospital purchases); air conditioning units; motor cars. Pleasure travel, except to sterling countries, is out.

The quota list includes citrus fruits, onions and potatoes, as mentioned above; textiles, leather goods, watches and cutlery.

A special excise tax of 25 per cent is to be levied on a wide range of less essential domestic articles. These include many household electrical appliances, refrigerators, stoves, oil burning equipment, self-propelled boats (except for commercial use), outboard motors, projectors and films, and all toilet articles. A stiff increase is made on Canadian-made motor cars. On the other hand, some savings take place on coal, sugar, tea and coffee.

Unfortunately the picture is still confused and it is difficult to interpret press comments in view of the frequency with which political bias and the opportunity to make political capital are permitted to colour any appraisal of the situation. That drastic action is necessary seems only too clear; that we could well live on a slightly lower scale of luxury must be obvious. Certainly we shall not suffer much by restrictions on cosmetics or on so-called "comic" magazines.

It can be taken for granted that these restrictions will add greatly to the cost of equipping new hospitals and will still further retard hospital expansion.

If essential equipment, not likely to be made in Canada, is unobtainable, the Council must make every possible effort to have special import arrangements made. Restrictions on imported fresh and canned fruits and vegetables may be a problem in hospital diets at times but essentials like citrus fruits and bananas are permitted entry. In all probability the net result, for the time being at least, will be added hospital costs and some inconvenience and interference with efficient diagnosis and care. We shall still be able to go to conventions across the line if we live abstemiously. This winter, too, absentee board members may be able to hold a trustees' convention when they congregate in Bermuda rather than be scattered all over Florida and California.

State Support and Control in New South Wales

A DISTINGUISHED visitor to Canada in recent weeks has been Dr. Alan B. Lilley, Chairman of the Hospital Commission of New South Wales. On a previous visit some years ago, he was getting ideas for the new buildings of the Royal Prince Alfred Hospital in Sydney of which he was then the administrator. He gave us much interesting information on how hospital affairs are worked out in Australia, both at the Council meeting in Winnipeg and at the Ontario meeting in Toronto.

Hospital affairs in New South Wales are directed by a Commission of three, appointed for seven years (renewable) and with the stipulation that one must be a medical man. Every hospital must be licensed under either the public or the private hospital enactment; some Sisters' hospitals are under both. Each hospital, except ecclesiastical ones, must have a board of directors of nine to twelve, and of these, four (or five, if the board is twelve in number) are named by the Government. The Commission has wide powers indeed; for instance, it must approve the appointment of a superintendent and can even remove a board of trustees if this action is in the public interest. Dr. Lilley states that this power has not had the effect of reducing local support.

No hospital can build or solicit funds without the approval of the Commission. A state survey by the Commission led to a master plan of development in which the state was divided into zones and rings marked with the types of hospitals needed. New development must conform to this pattern. New construction must provide basic services adequate for subsequent enlargement of the bed accommodation. The community raises what it can for building and the state provides the balance. Despite the fact that New South Wales covers some 300,000 square miles, very few people, except those in the far west, are more than thirty miles from a good hospital. In the rough areas of the far west, flying doctors, connected with well equipped hospital centres, take expert aid to the patient or the aerial service brings the patient to hospital.

With respect to operational finance, the state subsidy or grant is not on a per diem basis. Hospitals submit a budget to the Government, indicating anticipated earnings and the likely deficit. This is carefully checked, as is also the organization and operational procedures of the hospital. If all are approved, the Government undertakes to underwrite losses up to the estimated deficit as approved. Hospitals are encouraged to use the group purchasing facilities of the Government stores department.

In 1946, the Federal Government of Australia provided public ward care without charge and, in compensation, have been paying to hospitals the equivalent of their loss. The Commonwealth also pays towards the care of semi-private and private patients.

This program has meant a heavy financial obligation to the state. To help its financing of these measures, the state operates a lottery, a procedure not favoured in this country. The annual yield of this lottery—about three and one-half millions of dollars—goes into consolidated revenue. Fortunately for them, the other states do not have similar lotteries.

It is of interest that, apart from the administrators of the comparatively small number of Sisters' hospitals, there are practically no nurse administrators. In the cities, 90 per cent of the administrators have a medical background. Medical records and professional audits are not as good as here. In N.S.W. the nursing course is four years with an extra nine months for obstetrics. Authorities there are convinced that a fair degree of centralization of authority is essential for efficiency and economy. In rural areas a good diagnostic service is now provided, but the Government is working towards a system of full time salaried medical officers in these areas. We hear a good deal about the high taxation in Australia and it is interesting to learn how some of these funds are being applied.

Use of
Present Electro-Therapy Equipment
Permitted Under Certain Conditions

DISTRICT Superintendents of radio may authorize the use of present electro-therapy equipment until it can be replaced or radio interference suppressed, provided that no essential services are interfered with, and that reasonable effort is made to expedite the change-over.

This authority has been stated in a letter received by the Canadian Hospital Council from Mr. J. C. W. Browne, Controller of Radio. Aside from this concession the Department of Transport is definite in its intention to proceed with the announced plan of requiring hospitals and physicians to control interference by January 1st, 1948.

This letter was in reply to the resolution passed by the Canadian Hospital Council in October, urging further delay in implementation of these restrictions in view of the difficulty of obtaining suitable equipment in adequate quantities. The reply refers also to the desire of the Council that Canadian regulations would not be more stringent than those in the United States where users of present equipment are being given five years in which to make the change-over.

Mr. Browne's letter is as follows:

"As interference to radio communications, particularly to such safety services as aids to navigation, police, etc., has been increasing at a rapid rate, this Department, since 1936, has been endeavouring to find a satisfactory means of control.

"Section 23 of the Canadian Broadcasting Act, 1936, prescribes, in part, as follows: 'The Governor in Council may make regulations prohibiting or regulating the use of any machinery, apparatus or equipment causing or liable to cause interference with radio reception . . .'

"On the 22nd of January, 1941, an order-in-council was passed containing regulations for controlling radio interference, Regulation 3(a) of which reads as follows: 'No person shall operate any device emitting radio frequency oscillations for purposes other than radio communications licensed by the Minister except with the approval, in writing, of the Minister.'

"In December, 1941, the following information was widely distributed: 'Interference from radio frequency generators not used for communication, including tube-type diathermy machines, induction furnaces, etc., will be brought under control as soon after January 1st, 1944, as metal for shielding becomes available . . .'

"Due to the shortage of supplies during the war, the date for commencement of control was postponed to January 1st, 1948, as announced in our circular S11-13-28, December, 1945.

"During all this study, we have received the whole-hearted co-operation of the medical profession in Canada through the representatives of the Canadian Medical Association on committees and by many practitioners, individually. Representatives of the Canadian Medical Association have been very helpful on the committees of the Canadian Standards Association since its first meeting in Toronto on December 16th, 1938, and have since assisted in preparing C.S.A. Specification C 22.4 No. 106, which is used for the basis of control of interference from industrial, scientific, and medical equipment.

"It will be seen from the above that the Department has postponed the enforcement of the regulations for over six years, during which time the interference to radio communications has become very serious.

"The resolution passed by the Canadian Hospital Council has received serious consideration. At the same time a thorough study of interference on the high frequency communication channels has been made, and it has been definitely established that, unless the suggested controls are made effective in the immediate future, very serious disruption of many essential services will follow. It is, therefore, imperative that the control of industrial, scientific, and medical high frequency generating appliances take effect on January 1st, 1948, as already announced.

"Reference is made in the resolution to the five-year period of grace which, under certain conditions, is being allowed by the United States Government. Radio reception conditions in Canada differ considerably from those in the United States, particularly in respect to the natural static level and the great distances to be covered in a country so sparsely populated as ours. Because of these condtions, it is not only possible, but also economically necessary that communications be carried on with transmitters of lower power than are commonly used in the United States, and it follows that much more rigorous control of interference will have to be maintained in this country. These reasons have dictated the policy of enforcing the necessary suppressive measure immediately, and a further five-year extension of time would delay a proper development of other high frequency services which are essential to the economic and industrial advancement we all desire.

"The difficulty experienced in obtaining adequate screening material or a sufficient number of properly constructed new type machines was anticipated and referred to in our circular S11-13-28, which was first published in December, 1945. In this circular a measure of relief is offered to those who find it impossible to comply immediately.

"Our District Superintendents of Radio have been notified that they may issue written authority for the use of present equipment until it can be replaced or suppressed, provided that no essential services are interfered with and that a reasonable effort is made to expedite the change-over. This authority may be withdrawn at any time when interference is shown or when any unnecessary delay is evident."

Special Construction

The sections concerning special and emergency cases in circular S11-13-28, referred to in Mr. Browne's letter in the second last paragraph are as follows:

8—Special Cases

Special consideration may be given to exceptional conditions, when a departure from the general procedure may prove satisfactory and more economical. Such consideration may be given to:

(a) Emergency Cases. Radiation caused by the operation of interfering apparatus in cases of emergency is

dealt with under Section 4 of the Regulations for Controlling Radio Interference. This privilege of emergency operation should not be abused. Cases involving the use of electro-medical apparatus for patients who cannot be moved to a shielded room or otherwise given the desired treatment, without causing radiation, may be classed as emergencies. The use of violet-ray and diathermy aparatus in private homes, hospital wards, beauty parlours or barber shops, and in all cases where the patient can safely be moved to a shielded room, should not be considered cases of emergency. Hospitals in the habit of using interfering equipment in the ordinary wards should be provided with a shielded room or other means of suppressing the radiation, in order that no interference may be caused by the treatment of patients whose conditions would permit them to be moved with safety.

[Section 4 of the Regulations (mentioned above) reads as follows: No prosecution for an offense against these regulations shall be commenced except with the consent of the Minister and, without limiting the generality of the foregoing, the Minister may withhold such consent when, in his opinion, the device or apparatus was used for essential purposes in an emergency and the user submits a full report in writing to the Controller of Radio of the Department of Transport, not later than five days after the use thereof, and, on the requisition of the Minister, furnishes satisfactory proof that the use of the apparatus was for essential purposes in an emergency.]

(b) Surgical. Radiation from R.F. generators used excusively for surgical purposes (such as cutting, coagulation, desiccation and fulguration) and operated occasionally, for periods of a few seconds, may not require suppression provided it does not interfere with essential communications.

9—Cases where Shielding is not Practicable

Where the electro-therapeutic apparatus is operated without shielding (other than cases of emergency) only apparatus which operates within specified frequency bands shall be used.

There may be unavoidable delay in obtaining apparatus of this type, and users of equipment of the type without approved frequency stability may continue to operate their apparatus for a reasonable time by obtaining authorization from the Department of Transport in writing. This authorization will be issued only on condition that essential services are not affected and when the application for authorization is accompanied by proof of intention to instal apparatus which will operate within the allotted frequency bands, i.e., by having ordered such equipment.

Permitted Frequencies

Certain fundamental frequencies for electro-therapeutic equipment have been authorized by the Dominion Government. These were modified slightly at the 1947 International Radio Communication Conference in Atlantic City, the new frequency allocations going into effect in 1949. Equipment manufactured during the past year has incorporated the frequencies authorized by the Dominion Government. It was unfortunate that just at a time when the government was requiring hospitals to instal equipment with narrow frequency bands only that the bands should be changed. Although the change is slight we understand that, in some cases, replacement of certain units is required, while in other types only a modification of the circuit arrangement is necessary. Any equipment now in use with the following fundamental frequencies may be used up to January 1st, 1950.

Fundamental frequency 13,660 kc/s:
Upper limit—13,653. kc/s
Lower limit—13,667. kc/s

Fundamental frequency 27,320 kc/s:
Upper limit—27,160. kc/s
Lower limit—27,480. kc/s

Fundamental frequency 40,980 kc/s:
Upper limit—40,960. kc/s
Lower limit—41,000. kc/s

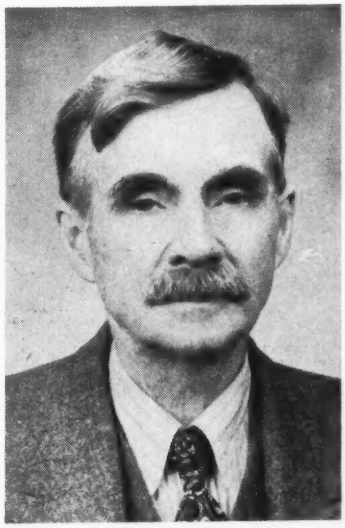
Manufacturers are now being urged to conform to the adjusted wave lengths in making equipment, although the required change-over in wave length does not take place until 1949. Revised frequencies required on any new electro-therapeutic equipment are as follows:

Fundamental frequency 13,560 kc/s:
Upper limit—13,553.2 kc/s
Lower limit—13,566.7 kc/s

Fundamental frequency 27,120 kc/s:
Upper limit—26,957.3 kc/s
Lower limit—27,282.7 kc/s

Fundamental frequency 40,680 kc/s:
Upper limit—40,659.7 kc/s
Lower limit—40,700.3 kc/s

A Record of Service



Robert G. Wood

Forty-one years of service in any capacity is something of a record, but forty-one years as a trustee on a hospital board deserves special credit. Such is the service which has been rendered by Mr. Robert Wood on the Board of the Lady Minto Hospital, Melfort, Sask. The only break in this long period was while he was overseas during the First World War. Besides being an active board member, Mr. Wood still conducts his own real estate and insurance business.

Regional Representatives

The following are the regional representatives of the Radio Division, Department of Transport:

The District Superintendent of Radio,
Department of Transport,
413-418 Belmont Building,
Victoria, B.C.

The District Superintendent of Radio,
Department of Transport,
404 Public Building,
Calgary, Alta.

The District Superintendent of Radio,
Department of Transport,
400-401 Public Building,
Regina, Sask.

The District Superintendent of Radio,
Department of Transport,
539 Public Building,
Winnipeg, Man.

The District Superintendent of Radio,
Department of Transport,
566 Dominion Public Building,
Toronto, Ont.

The District Superintendent of Radio,
Department of Transport,
400 Youville Place,
Montreal, P.Q.

The District Superintendent of Radio,
Department of Transport,
P.O. Box 217,
Halifax, N.S.

Record Attendance at O.H.A. Annual Meeting

LAST month, on November 3rd, 4th and 5th, the Ontario Hospital Association Convention got under way at the Royal York Hotel in Toronto, with a record registration of well over 900 as compared with over 700 last year. The discussions were many and diverse since sessions of the various sections were taking place throughout the convention period. Among those taking an active part were a number not only from Canada, but from other countries as well, including Dr. Malcolm T. MacEachern, Chicago, Dr. Alan B. Lilley, New South Wales, Dean Conley, Chicago, and Miss May Kennedy, Reg.N., Cornell University, New York.

Increasing Costs Discussed

Increasing costs and how to meet them seemed to be of major concern to all present. It was pointed out that costs had increased steadily from September 1946 to May 1947, and in these ten months the percentage of increase had risen as much as in the previous three years. Furthermore, figures for 1946 costs are already out of date. Provinces, municipalities and patients have contributed to the upkeep of hospitals, but, at the present time, the amount of revenue received from these sources is inadequate and the big question appeared to be "Where is it to come from?"—by increasing the charges to patients or by a subsidy from other sources, or both?

During the course of the general discussion, it was brought out that in one hospital the biggest loss was incurred from indigent patients, while in another hospital paying public-ward patients caused a great part of the loss. Mr. R. J. Weatherill of St. Catharines expressed the opinion that since the individual's earning capacity is greater than formerly he should bear some of the rising costs and that, in the paying general-ward rate, provision should be made to cover extra services or a charge made for them. Mr. Fraser Armstrong, Kingston, stated that the people of Ontario should think of assistance to hospitals in terms of assistance to people who have to pay hospital bills. Paying for illness is becoming more and more of a hardship for those people who are not indigent but are poor.

Mr. Moffat, of the Ottawa Civic Hospital, discussed at length the ways and means of procuring satisfactory payment from surrounding municipalities for indigent patients; and Mr. C. J. Telfer, Inspector of Hospitals for Ontario, suggested the possibility of the appointment of a responsible person to arbitrate the question of what constitutes an indigent. Dr. Fines of Mt. Sinai Hospital, Toronto, contributed the suggestion that some sort of organized publicity campaign be conducted to educate the people to the needs of the hospitals. Dr. Crozier of London was emphatic in his opinion that hospitals should be subsidized for the purpose of nurse training. In any classification of hospitals for grants, he felt, consideration should be given to the educational services provided as well as service to patients. Dr. Crozier also gave a number of practical suggestions for meeting the problem of overcrowding, such as cutting down the patient day, more practical nurses to care for patients at home, more attention to chronically ill persons, more social workers for follow-up work, et cetera.

J. MacIntosh Tutt, Brantford
Newly-elected president, O.H.A.

Medical and Hospital Insurance Plans. At a round table discussion of medical and hospital prepaid plans, Dr. Melville C. Watson gave a detailed account of the formation of the new O.M.A. plan, Physicians Services Incorporated, and stated that the demand for a prepaid plan had come from three sources—the public, the people, and the profession. The hope was expressed that eventually 75 per cent. of all employed persons will become subscribers.

Dr. Fred W. Routley, secretary-treasurer of the O.H.A. and now Acting Director of the Plan for Hospital Care, reviewed the growth of the Plan and emphasized that its Board was very much in favour of the new medical and surgical plan since it would complement the prepaid hospital plan.

Dietary Section. The dietary section was conducted by Miss Jean MacDiarmid, Acting Supervisor of Dietetic Service, Department of Veterans Affairs, Ottawa, who outlined the duties of a hospital dietitian. Papers on personnel, equipment, preparation and service of therapeutic diets, and the organization of a dietary department were presented.

Nurse Administrators. There was a good deal of discussion at the nurse administrators' section on the value of a shorter period of training for nurses. Miss Agnes McLeod, Director of Nursing, D.V.A., referred to the demonstration school at the Metropolitan Hospital in Windsor. Pension plans and salaries also came under

discussion, and the suggestion was made that hospital associations take the lead in obtaining information regarding salaries paid to other professional groups so that some satisfactory schedule might be worked out.

Two New Sections. Two new sections were set up within the O.H.A. Representatives of the hospitals for the chronically ill and incurable held a dinner meeting and the next day many delegates visited the Queen Elizabeth Hospital, where a new building is being prepared for the accommodation of chronic patients. The officers elected are: *Chairman:* Dr. P. J. G. Morgan, East Windsor Hospital; *Vice-chairman,* Miss Pearl Morrison, Queen Elizabeth Hospital; *Secretary,* Mr. A. M. Waller, St. Peter's Infirmary, Hamilton.

About seventy-five of the delegates attended an accountants' meeting under the chairmanship of R. J. Weatherill, St. Catharines. Mr. C. J. Telfer spoke on the importance of accurate accounting and Mr. O. G. Smith of the O.H.A. staff, member of the Joint Committee on Hospital Accounting, demonstrated the use of the new approved forms of accounting now in general use. In this connection stress was laid on the importance of uniformity of accounting systems and common nomenclature throughout all hospitals to aid in the understanding and working out of common problems. Officers of this new section are: *Chairman,* Mr. F. Moffat, Ottawa Civic Hospital; *Vice-chairman,* Mr. H. Krafft, Sarnia General Hospital; *Secretary,* Mr. E. R. Willcocks, Toronto General Hospital.

Trustees. At a section meeting of the trustees the duties of the administrator and the trustee were discussed. Mr. J. M. Tutt, in summing up, stated that "the function of a superintendent is to administer and operate the institution. The function of the trustee and the board is to adjudicate and direct policy. A good board of trustees will not become a board of management because, after all, hospital administration is a highly specialized field".

Pension Plan. At a banquet on Tuesday evening, Mr. J. MacIntosh Tutt, newly-elected president, paid glowing tribute to Miss Priscilla Campbell, retiring president. The latter, in an impressive address, stated that the aim of the association is to assist its members to find solutions to problems concerning administration and to provide the best possible care for patients at the least possible cost to patients. She also mentioned that the pension plan for hospital employees has now reached a point in development where the Association undertakes, without cost to hospitals, the entire administration involved in setting up such a plan. Hospitals are invited to get in touch with the head office promptly to obtain whatever assistance is necessary to get such a plan under way.

Officers Elected

Honorary President: **The Honourable Russell T. Kelley**

Hon. Vice-president: **Miss Priscilla Campbell, Chatham**

President: **J. McIntosh Tutt, Brantford**

President-elect: **Miss Pearl Morrison, Toronto**

1st Vice-president: **Douglas Piercy, M.D., Ottawa**

2nd Vice-president: **Sister M. Pascal, Chatham**

3rd Vice-president: **H. H. Browne, Fort William**

Secretary-treasurer: **F. W. Routley, M.D., Toronto.**

Board of Directors

G. Harvey Agnew, M.D., Toronto; Horace Atkin, Windsor; Fraser Armstrong, Kingston; Rahno M. Beamish, Reg.N., Sarnia; J. H. W. Bower, Toronto; J. S. Clark, Owen Sound; L. J. Crozier, M.D., London; Rev. Father John Fullerton, Toronto; John Hornal, Peterborough; Senator J. R. Hurtubise, Sudbury; Sister Louise, Toronto; Mrs. W. C. Mikel, Belleville; M. T. Morgan, Toronto; G. A. Reid, Toronto; A. L. Richard, M.D., Ottawa; A. J. Swanson, Toronto; C. M. Weber, Kitchener; R. J. Weatherill, St. Catharines; John E. Sharpe, M.D., Toronto.

—E.S.

Canadian Record Librarians Hold Thirteenth Meeting

The thirteenth annual conference of the Canadian Association of Medical Record Librarians was held on November 3rd and 4th at the Royal York Hotel, Toronto. Delegates attended from many points in Ontario and Quebec, and representatives were present from Winnipeg, Detroit and Chicago.

Mrs. James Prenderleith, R.R.L., Kingston, and Miss Isabel Marshall, R.R.L., Brantford, delegates from the Canadian Association who attended the nineteenth Annual Conference of the American Association of Medical Record Librarians held in September, reported their observations and outlined the highlights in an entertaining manner.

For the first time in the history of the Association, a delegate from the American Association of Medical Record Librarians was guest of the Canadian Association. Mrs. Althild Norris, Chicago, who is past-president of the A.A.M.R.L., spoke on provincial organizations. Other interesting papers presented were: "Interdepartmental Relations of the Medical Record Librarian as Viewed by the Hospital Administrator"—Dr. L. J. Crozier, Superintendent, Victoria Hospital, London; "How Important is the Medical Record in the Treatment and Care of the Patient?"—Dr. R. F. Farquharson, Professor of Medicine, University of Toronto; "Microfilming of Medical Records"—Mr. D. J. Sinclair, Hospitals Credits Service. An interesting round table discussion was led by Dr. Malcolm T. MacEachern and Dr. Harvey Agnew.

Honour was paid to Miss A. Stella Hall, as retiring president, and much credit accorded to her and to Miss Anne Campbell, chairman of the program committee, for the success of the meeting.

Officers for 1948 are:

President: **Mrs. James Prenderleith, Kingston**

1st Vice-president: **Sister St. Cyprian, Toronto**

2nd Vice-president: **Miss Alma Allison, Toronto.**

Secretary: **Miss Marie Restivo, Toronto.**

Further Government Aid Urged by British Columbia Hospitals

THE thirtieth Annual Convention of the British Columbia Hospitals' Association was officially opened on October 30th, at the Empress Hotel in Victoria. Mr. R. A. Pennington, the new Deputy Provincial Secretary, speaking on behalf of the Hon. Mr. George S. Pearson, welcomed to the two-day convention over one hundred delegates from the member hospitals.

Interesting reports on activities were given by the President, Mr. J. V. Fisher, the Secretary, Mr. E. W. Neel, and the Treasurer, Mr. J. E. O'Mahoney, following which the various committees of the Association presented their reports. Mr. Percy Ward, Chief Inspector of Hospitals and Institutions, gave an account of the year's work. Considerable discussion took place on the problem of keeping hospitals informed of developing trends and, as a result, the suggestion was made that the Inspector's Department should issue quarterly reports to the hospitals.

The president of the Canadian Hospital Council, Mr. A. J. Swanson, addressed the meeting during the afternoon session, outlining the work of the Council and the Council's biennial meeting in Winnipeg. The section on nursing was divided into three parts. Sister Mary Loretto, St. Joseph's Hospital, Victoria, spoke on "The Practical Nurse in the Hospital Field". Miss Helen King, Assistant Director of Nursing, Vancouver General Hospital, addressed the meeting on "The Nursing Care of Anterior Poliomyelitis", and Miss Edith Green of the Royal Jubilee Hospital convened a panel discussion concerning "The Shortage of Applicants to Schools of Nursing".

On the last morning of the convention, Mrs. L. McCulloch addressed the meeting on behalf of the Women's Auxiliaries, and the Regional Committees of the Association made their reports. The resolutions committee, summarizing the deliberations of the various sessions, then submitted their proposals to the whole meeting. The major resolutions dealt with the following matters:

In order that hospital costs might be measured more accurately, a special committee should be set up to co-ordinate reports on morbidity and other statistics to be supplied by the larger British Columbia hospitals;

A request to the Provincial Government to increase the present grants by 100 per cent;

A request to the Provincial Government to open an Old People's Home in the interior of the province at Vernon, B.C.;

A request to the Provincial Government to increase the grants to those hospitals which do not have the advantage of receiving full municipal grants;

The endorsation of a program for province wide hospital insurance, owing to the fact that the present Health Bill, which includes both medical and hospital benefits, is not in operation at the present time;

A request that the Indian Affairs Department pay the prevailing rates to hospitals and that a special committee be appointed to act in this matter;

A request that steps be taken to reduce the age for nurse recruits from 19 years to 18 years;

A request that the Provincial Government set up a committee of members from the British Columbia Hospitals' Association and the Registered Nurses Association of British Columbia to deal with mutual problems;

A request to the Provincial Government to increase and subsidize the schools of nursing;

A request that the airlines not demand graduate nurses to serve as stewardesses;

A request for the inclusion of hospitals in the Yukon Territory as members of the Association;

A request that approval be given to the practice of having specially trained graduate nurses give intravenous injections (to support the legal position of the hospitals).

On the closing afternoon of the Convention, Mr. George Masters of the Vancouver General Hospital gave an account of the Western Institute for Hospital Administrators and Trustees which had been held in Edmonton the previous week. Other speakers were: Mr. W. G. Welsford, Managing Director of the British Columbia Blue Cross, who spoke on the activities of the Blue Cross; Dr. Walter Rice, Provincial Director of the Red Cross transfusion service.

Officers Elected

Honorary President: **Hon. George S. Pearson**

President: **K. K. Reid, New Westminster**

First Vice-president: **A. H. J. Swencisky, Vancouver**

Second Vice-president: **J. E. O'Mahoney, Summerland**

Treasurer: **George Masters, Assistant Director, Vancouver General Hospital.**

Mr. E. W. Neel will continue as Secretary until the end of the year when Mr. Percy Ward will take over.

—*G. M.*

New Officers Elected by Manitoba Conference, C.H.A.

The annual meeting of the Catholic Hospital Conference of Manitoba, was held in St. Boniface during October, in conjunction with the biennial meeting of the Catholic Hospital Council of Canada. The following are the officers and directors elected for the coming year:

President: Sister Mary of the Nativity, St. Joseph's Hospital, Winnipeg.

Vice-President: Sister St. Gertrude, Superior, Misericordia Hospital, Winnipeg.

Secretary: Sister M. Stanislaus, St. Joseph's Hospital, Winnipeg.

Directors: Sister A. Boisvert, Superior, St. Boniface Hospital, St. Boniface; Sister Delia Clermont, Director of Nurse Education, St. Boniface School of Nursing, St. Boniface; Sister Justina, Superior, Sacred Heart Hospital, Russell; Sister Larocque, Superior, Flin Flon General Hospital, Flin Flon.

The British Columbia Catholic Hospital Convention

THE British Columbia Conference of the Catholic Hospitals Association met for its ninth annual convention at Victoria, October 27th to 29th.

His Excellency Most Reverend Wm. M. Duke, Archbishop of Vancouver, offered the Holy Sacrifice of the Mass in the Hospital Chapel. In his sermon His Excellency pointed out the significance of the Conference motto "The Charity of Christ Urges Us" showing the reason for the work undertaken in our Catholic hospitals and the character that should be engraven upon it, for the good of humanity.

Mr. Joseph McKenna presented messages of welcome to Their Excellencies, Most Rev. Wm. M. Duke and Most Rev. J. M. Hill, Bishop of Victoria. On behalf of the medical profession, Dr. D. B. Roxburgh, Medical Superintendent of St. Joseph's Hospital, welcomed the Sister delegates from the sixteen member hospitals of the Pacific Conference. Rev. Father H. L. Bertrand, S.J., President of the Catholic Hospital Council of Canada, presented greetings from his executive to the assembly.

His Excellency Bishop Hill outlined the importance of the Catholic Hospital as an institution of charity, of healing, of prevention of sickness, and of individual and social education. He indicated likewise some of the difficult problems that plague both civic and voluntary hospitals.

Rev. A. J. McGowan, Chaplain of the Conference for the past three years, brought his usual earnest concern to the proceedings and expressed sincerest thanks to all for their participation in the program. Sister Columkille, President, then delivered her report which outlined the great volume of work accomplished, presaging the need for keeping abreast of provincial and national developments in the nursing field, in order that Catholic hospitals may continue to maintain and to extend their sphere of influence for the greater good of mankind.

Highlights of the afternoon's proceedings were the reports of the standing committees on Nursing Education, Legislation and Publicity, the Question Box on ethical and legal problems under Rev. Dr. G. Hayes, S.P.M. and Mr. A. J. Swenciski; two excellent papers by Miss G. Wahl, Reg.N., one on labour relations as they affect the nurse and the hospital, the other a report on the development of the Vancouver Council of Catholic Nurses; and Rev. Father H. L. Bertrand's talk on hospital trends, East and West.

Sister Mary Celina, F.C.S.P. and Sister Mary Evangelista, C.S.J., delegates to the Canadian Hospital Council meeting in Winnipeg early in October, made complete reports on proceedings there. These two Sisters had messages also from the Edmonton Institute on Hospital Administration held immediately after the Winnipeg convention. Sister Mary Claire, S.S.A., reported on the Catholic Hospital Council of Canada meeting in St. Boniface, October 13th. Sister Mary Grace S.S.A., gave a paper on the nursing care most suitable for chronic and incurable patients. The question of "practical" nurses was discussed by Sister Leo Frances and Sister Ann of the Sacred Heart.

Sister Helen Marie, F.C.S.P., St. Paul's Hospital, Vancouver, former secretary of the Conference, succeeds Sister Columkille as president. Sister Mary Mildred, S.S.A., was chosen First Vice-president and Sister Mary Evangelista, C.S.J., second Vice-president, Sister Priscilla Marie, F.C.S.P., Secretary-treasurer.

Rev. A. J. McGowan, Chaplain of the Conference, solicited a withdrawal from office this year. During the three years the Reverend Father held office he has been most zealously devoted to the great cause. His interest will still be counted upon by the members of the Conference who are gratefully appreciative of all that he has done. He will be succeeded by Reverend Dr. G. Hayes, S.P.M., to whom the Conference accords sincere welcome.

—Sister Mary Dorthea, S.S.A., Victoria, B.C.

Two-Day Administration Course in Victoria Well Attended

Men and women from all parts of British Columbia attended the course on hospital administration which was held in Victoria on the two days immediately preceding the British Columbia Hospitals' Association convention. Seventy-seven government-aided hospitals and thirty-five private hospitals were represented at the course which was organized by Mr. Percy Ward, Chief Inspector of Hospitals and Institutions.

Speaking at the opening session, Mr. A. J. Swanson, president of the Canadian Hospital Council, brought to the attention of the delegates the common difficulties which are facing hospitals across the Dominion. He pointed out the necessity of facing squarely the major problems of shortage of personnel, the increased cost of both personnel and material and general "sky-rocketing costs".

Mr. Ward, speaking on the "Principles of Hospital Administration", emphasized the responsibility of the boards of management of hospitals in defining what the particular hospital is for and what it is prepared to do. He said that the initiative in such definition must come from the administrator.

Other speakers were: Mrs. Edith Pringle, Reg.N., Inspector of hospitals and institutions for the Provincial Government; Mr. Allan McLean, Inspector of hospital accounting; Mr. G. Ruddick, Vancouver General Hospital; Mr. J. Madeley, Royal Jubilee Hospital; and Miss E. N. Y. Love of the Provincial Health Branch.

The course was concluded by a round table discussion under the leadership of Mr. A. J. Swanson. All delegates expressed their appreciation of this feature of the Institute which was particularly informative and stimulating.

With the Auxiliaries

Annual Meeting of Ontario Women's Aids

The Women's Hospital Aids Association of Ontario held its annual convention concurrently with that of the Ontario Hospital Association at the Royal York Hotel in Toronto last month. The president, Mrs. J. Graham Harkness, opened the meeting and Mrs. O. W. Rhynas, founder and past president of the association, extended greetings and gave a very full review of public relations work during the past year.

Reports of the various committees were received and a resolution was made to the effect that since the times demand ever-widening knowledge, advantageous contacts and co-operation of all voluntary Women's Hospital Aid Groups, it would seem desirable to form an advisory council composed of two appointed members from each of the provincial organizations. This unit would function as a clearing house in dealing with the various problems and phases of the work and co-operate with the Canadian Hospital Council.

A cable was sent to Her Royal Highness the Princess Elizabeth extending good wishes on the occasion of her marriage.

One of the highlights of the convention was the breakfast meeting on the opening day. Among the guests of honour from outside the Province were Mrs. Plummer, Victoria, B.C., Brigadier Pearl Payton, Manitoba, Dr. Alan Lilley, Sydney, N.S.W., and Dr. Malcolm MacEachern, Chicago.

Officers elected for 1948:

President: **Mrs. J. Graham Harkness, St. Catharines**

Treasurer: **Mrs. Chas. W. Sim, St. Catharines**

Corresponding Secretary: **Miss Nettie F. Boyle, St. Catharines.**

The Ladies Guild of St. Joseph's Hospital, Winnipeg, have spent a busy year, their latest contribution to the hospital being an electric food conveyor.

Hospital Aids Convention in Saskatchewan

Forty-five delegates, representing twenty-four units of the Saskatchewan Hospital Aids Association, registered for the seventh annual convention held at the Bessborough Hotel, Saskatoon, in October.

In her presidential address, Mrs. P. S. Stewart of Regina noted that a special attempt had been made during the past year to interest non-affiliated units in the provincial association, with the gratifying result that sixteen new groups had become members. Reports from thirty-two of the groups indicated that $27,185 had been raised for hospital purposes.

One project of the Regina General auxiliary had been the refurnishing of the nurses' sick ward and the providing of new mattresses for the nurses' residence. The patronesses of the Regina Grey Nuns had taken a special interest in the children's ward, and had also purchased a dictaphone for the doctors' office.

Officers elected for the year are:

Honorary president: **Dr. G. Harvey Agnew, Toronto**

President: **Mrs. P. S. Stewart, Regina**

Secretary-treasurer: **Mrs. E. E. Bishop, Regina.**

Pictured above are some of the members of the Manitoba Women's Hospital Aids who met at the Royal Alexandra Hotel, Winnipeg, in October, to hold their first annual convention. Left to right are: Mrs. L. S. Taylor, Hamiota; Mrs. W. J. Waddell, Winnipeg; Mrs. George McDonald, Boissevain; Mrs. J. M. George, Morden; Mrs. D. Loewen, Altona.

Here and There

By THE EDITOR

That Youth Congress in Czechoslovakia

THIS past summer a mammoth conference or Youth Festival was held in Prague in Czechoslovakia. We heard very little of it here in Canada. Yet over 85,000 young people from 71 different countries attended that congress! Anyone who knows how hard it is to get attendance at a voluntary conference from more than a score of countries and in numbers even up to 500, must realize what an amazing achievement this was. The vast majority had little money, transportation was difficult and some left their countries facing severe penalty and even prolonged sentence by so doing—but they came, thousand after thousand of them. Are we Rip van Winkles here? This Youth Festival was called by the World Federation of Democratic Youth (WFDY), a development initiated in London in 1941 by a group of young people representing some thirty countries who set up an International Youth Council, which later became the World Youth Council, meeting in London with over 600 delegates from 64 different countries. The WFDY was the outcome of that meeting.

The purpose of this organization has been to foster international understanding. As Sir Stafford Cripps said in his opening address in 1945, "The theory upon which we base our hopes is that it should be possible to get diverse groups of human beings of all sorts, sizes and descriptions, differing in every kind of way, to live together in the world in unity and concord, without the periodical eruption of war, to which we have hitherto been accustomed. Unless we can, by experiment, establish the truth of that theory . . . we must, I believe, accept the inevitability of the destruction of our civilization at no very distant date."

This organization, through its member associations, is said to represent some 48,000,000 young people, truly a body to be given more consideration than has prevailed hitherto. By its constitution, the Federation "shall regard its work as a contribution to the work of the United Nations and as the most certain way of ensuring the protection of the rights and interests of youth, and the happiness and well-being of future generations". Among its aims are: to strive for close international understanding and co-operation amongst the youth in all fields; to contribute to the elimination of all forms of fascism and assist governments in ensuring peace and security and the bringing up of the new generation in a democratic spirit; to encourage young people to participate in public affairs; to work for good conditions for education, labour and leisure; and to educate youth in the ideas and responsibilities of world citizenship.

Some 90 Canadian and 200 American youths attended this great demonstration—a fair representation but not in keeping with the importance to these countries of this Festival. A member of the writer's family attended as an observer and representative of "Varsity", the University of Toronto undergraduate newspaper, and found himself with a very interesting group of Canadians, ranging from one lone Conservative to the better represented Labour-Progressives. The Canadians represented trade unions, student organizations, cultural and language groups. McGill sent the most students (25); the largest group (30) represented the National Federation of Labour Youth. It was unfortunate that the Y.M.C.A., Y.W.C.A., church groups and the traditional political parties were very inadequately represented. Serious members of the delegation were strongly of the opinion that critics of participation had done a real disservice to Canada, for "Canada could have done much better than she did in trying to present our way of life, our concept of democracy".

Apparently the month-long congress was a tremendous success. In addition to the prolonged discussions of international problems of vital concern to youth, there were nearly 300 cultural events, including concerts, folk dance competitions and drama, as well as a number of athletic events. Young people of all nations and of varied ideology found much in common and had broken down for them many pre-conceived notions about the other fellow.

One frequent criticism of this meeting, even before it took place, was that it was dominated by communists. Because of this suspicion some organizations did not send delegates. This would seem to have been a short-sighted policy, for the only result was to weaken the voice of the democratic groups at the meeting. Russia and her supporting countries, on the other hand, sent strong delegations and, as a result, were outstanding in the pageants, athletics, national concerts, et cetera. It will be difficult to win the youth of the wavering countries if the strongholds of democracy do not make an effort to defend their viewpoint, i.e., if they have any.

Many shrewd observations were brought home about Jugoslavia, in which country our young observer worked on Tito's "Youth Railway" in the Bosnian Mountains. But that is another story. Suffice it to say that the Canadian group were much impressed with the *spirit* of these young people behind the Iron Curtain. Their enthusiasm, their willingness to work and their loyalty to their leaders were a revelation to the westerners.

It was unfortunate that this meeting was called at the same time as the long-planned World Christian Youth Conference at Oslo, attended by more Church groups. This, too, tended to be leftist although without communists. It is of considerable importance that we take cognizance of this tremendous revolt of youth against war-mongering and the forces that tend to make wars. Never before has youth got together in such numbers and with such determination. We can see many dangers in this movement if the leadership is not sound; but, if movements like this are given proper support and sound youth leaders are encouraged to participate, the end result should be good.

Food and Its Service

Sponsored by the Canadian Dietetic Association.

Arrangements for a Special Luncheon

Doris Lockhart, B.H.Sc.,
Chief Dietitian,
Montreal General Hospital.

ONE'S first reaction upon being asked to serve a special luncheon is that it is impossible under present conditions. However, it can be done! The following report is based upon an actual luncheon which was recently provided for 180 doctors.

The problems were many and varied. The hospital dining rooms were already overcrowded, and the recreation room in the Nurses' Home, which is across a busy street, would take only one hundred comfortably for a buffet luncheon. We were faced with the familiar dish and tablecloth shortage, and it was difficult to obtain maid service as the waitresses were all busy in the dining room at that time.

The seemingly impossible was accomplished by using one of the large reception rooms in the Nurses' Home. Our major problem was the planning, arranging, and transportation of complete food service equipment. Hospital screens, large and small tables, pie racks, tray stands, and extra trays, were set up in duplicate in the two rooms. Two electric food conveyors were used for hot food. This necessitated the building of a ramp to cover the four steps at the entrance to the recreation room.

In planning the luncheon three important factors were kept in mind continually: maximum control of serving temperatures for food; smooth, prompt service requiring uncrowded conditions for efficiency; careful organization of all details.

Each small detail was considered and careful work plans made to ensure good service. Records of previous catering problems, with amounts, lists of equipment, sources of supply, organization and number of staff helped greatly. Previous points of criticism or suggestions for improvement were considered.

It is wise to secure an estimate of the attendance at least two weeks in advance. If it is a regular or yearly luncheon event, the numbers served previously may be checked, and other factors such as time, weather, day of the week and any conflicting activities may be allowed for. The variation between the estimated and the actual counts may be as low as 5 per cent.

The menu chosen was a popular one and, more important to us, it was easy to serve.

Tomato Juice Cocktail
Celery hearts, olives, radish roses, carrot sticks
Chicken a la King with hot tea biscuits
Deep Apple Pie a la Mode
Coffee

A complete list of necessary dishes and equipment was made. After ascertaining what was available in stock on hand, an order was placed with a catering firm which required two weeks' notice.

The luncheon date was set for Wednesday and by arranging for all possible details well in advance, very little remained to be done the day of the luncheon.

The division of work and procedure was as follows:

Monday

1. Orders were written for food supplies to be delivered to the main kitchen and bakery for the following day.

2. Work slips were made for the chef and baker. Amounts of orders, methods, yield and time for preparation were specified.

3. Requisitions for silver, extra dishes, trays and equipment from the storeroom were written, to be delivered to the dining room the following day for cleaning and polishing. Serviettes were also ordered and folded.

4. List of screens, and large and small tables required, was sent to the foreman's department to be delivered by orderlies the following day.

5. Ramps and door stops were made to order by the maintenance department. (Four steps at the entrance to the recreation room prevented the transporting of the electric food conveyor.)

6. Available personnel were listed and their services were secured.

7. It was necessary to make special arrangements for the delivery and care of the ice cream due to the shortage of dry ice.

Tuesday

1. The centre-pieces of short stemmed yellow roses were the least expensive flowers. Pink or red flowers that would clash with the color of the tomato juice were carefully avoided.

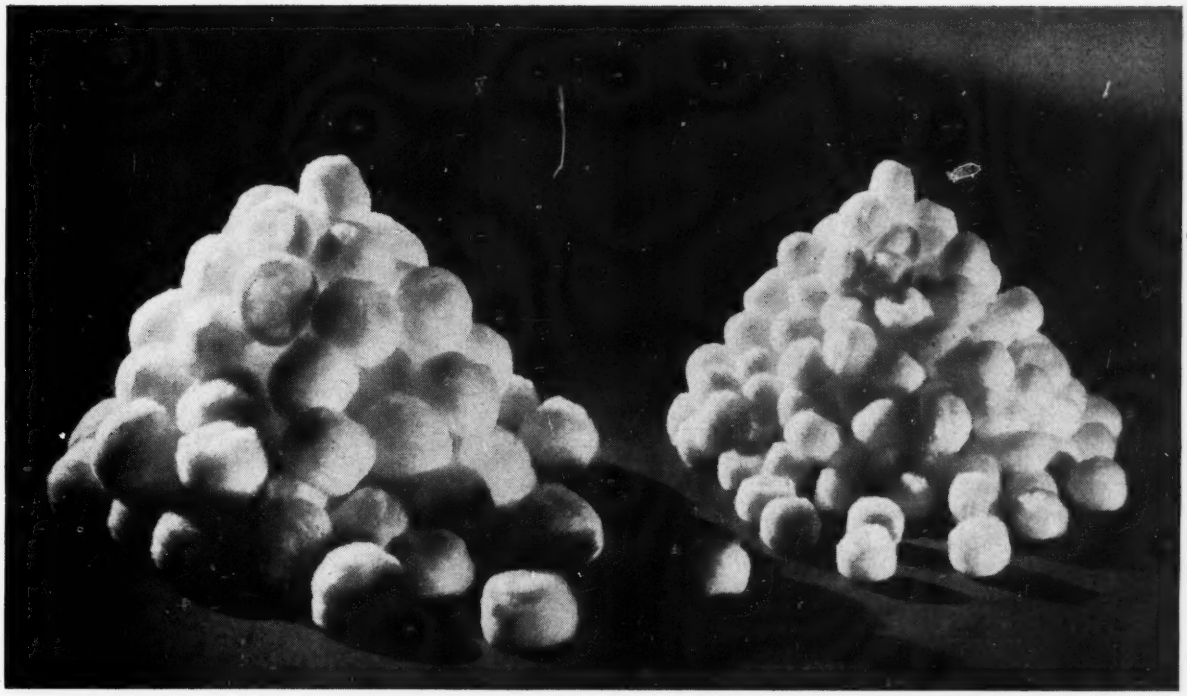
2. Supplies such as coffee, cream and sugar were requisitioned for delivery directly to the Nurses' Home the following morning.

3. The placing of tables, tablecloths, screens, pie racks, and tray stands was carefully arranged by the dietitians. Congestion was avoided by spreading out the serving areas, and each unit was organized for rapid service.

4. The cleaning and polishing of all dishes was completed. Serving equipment and extra dishes were assembled from the dining room and taken over on a large carrier to the Nurses' Home.

5. Rented dishes were distributed to each room and unpacked. A careful checking showed that many chipped and cracked cups and glasses had to be replaced.

6. Tables were set up with silver, serviettes, water and milk glasses, cups and saucers. These were cov-



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REG. IN CANADA

ered and the doors were locked over night.

7. Back in the main kitchen, the tomato juice was being well seasoned with pieces of celery, onions and spices—to stand over night. The celery hearts, radish roses and carrot sticks were prepared. The meat was tender and other supplies were in readiness.

Wednesday

Time schedule is indicated to show how easily work proceeds without any hurry.

10:00 a.m. The preparation of the apples, tea biscuits and pastry was checked again by the dietitian. The mushrooms, peas, celery and peppers were being cooked for the main dish. The chicken was cut to the right size. The tomato cocktail was tasted. The pies were well-timed, and would be ready before 11.30 — to be taken over to the Nurses' Home with the cold supplies.

10:30. Four dietitians proceeded to the Nurses' Home. Final arrangements were then made. The serving pantry was most inadequate. It was small and so narrow that two persons could pass only with great care. Hence, a methodical plan for the disposal and distribution of the soiled dishes was necessary, and only the plates were to be returned to the serving pantry for rinsing. Serving duties were arranged and stations assigned to each person.

11:00. Steam was turned on in the water urn (for making the coffee) and pressure checked. The ovens were heated for warming luncheon plates. Since there was insufficient space in the oven, half the plates had to be taken upstairs to another oven for heating. Plates were carefully checked at regular intervals. The flowers arrived and were arranged in low bowls.

11:30. Carrier arrived with supplies. Tomato juice was placed in refrigerator. The relishes were drained and arranged on large glass platters. The apple pies were cut and placed on 24 large trays (8 plates per tray). They were then placed directly in the pie racks behind the screens. (This eliminated a later carrying of trays up and down steps, and through crowded places.) A few sherbet glasses were added to meet any requests for plain ice cream.

11:45-12:15. Off duty.

12:15. In main kitchen the packing of the tea biscuits was checked and the chicken a la king tasted. The ice cream was carried in the bottom of the food conveyor. The carrier was to leave at 12:35 (10 to 15 minutes allowed for transportation).

12:30. Maids report for duty; sugar bowls filled; jugs of milk, ice water and cream placed in refrigerator until just before serving time; glasses of chilled tomato juice placed on tables.

12:40. Coffee started; tables given final checking; coffee tasted.

12:50. Food conveyors set up in place with luncheon plates, tongs for serving biscuits, ladles and several clean cloths; ice cream placed behind screen, on low chair for easier serving and scoops checked. Nurses arrived and serving plan was outlined.

12:55. Lunch was ready to be served and guests began to arrive.

In each room six graduate nurses passed the cocktail, relishes and chicken. The chicken was served from both sides of the carrier by two dietitians and a third served the tea biscuits and attended to the plate supply. The two maids quickly removed the soiled dishes.

1:00. An orderly was posted to notify the dietitian as soon as 90 guests were in the recreation room. The balance were then directed to the reception room. This precaution ensured an even distribution, upon which efficient service depended.

1:20. The desserts were started with two serving the ice cream.

1:30. Serving of coffee.

2:00. Lunch was served to those assisting with luncheon; rooms cleaned; dishes washed and repacked by maids; carriers loaded for return and serving pantry cleaned.

2:30. All evidences of luncheon were removed and operations completed.

However, it would never do to tell the chairman and all the others who made very complimentary remarks concerning the luncheon that it was mostly a matter of organization.

Ontario Medical Plan Discussed at O.H.A. Convention

At the O.H.A. Convention held in Toronto in November, Dr. Melville C. Watson, president of the newly formed medical and surgical plan, gave a detailed report of the origin and setting up of the organization. He stated that one of the first duties of the plan has been to educate the public and the profession as to how a democratic plan should work. This plan is governed by approximately 180 elected representatives, known as the House of Delegates, from the various branches throughout Ontario, headed by a Board of Directors composed of nine members.

The rates worked out are the minimum which will cover the essential services to the subscribers. There are two contracts being offered: A surgical and obstetrical plan for which the rates are—1 subscriber, 75c a month; 1 subscriber and 1 dependent, $1.75 a month; 1 subscriber and more than 1 dependent, $2.50 a month. This contract does not pay for doctors' services in doctors' offices or people's homes.

The complete plan covers medical, surgical and obstetrical service. This also includes office visits by patients and doctors' services in homes. The rates for this plan are—1 subscriber, $1.50 a month; 1 subscriber and 1 dependent, $3.50 a month; 1 subscriber and more than 1 dependent, $5.00 a month.

The plan will operate on a group basis only and will work in close co-operation with the Blue Cross. The first plan will be offered to groups of five or more and the second plan to groups of 15 or more.

A.C.S. Sectional Meeting Scheduled for Halifax

The American College of Surgeons has announced its sectional meetings for 1948. One of these will be held in Halifax on May 17th and 18th with headquarters at the Nova Scotian Hotel. Many hospital people in the western provinces will plan to attend the conference which will be held in Minneapolis on March 15th and 16th, with headquarters at the Hotel Nicollet.

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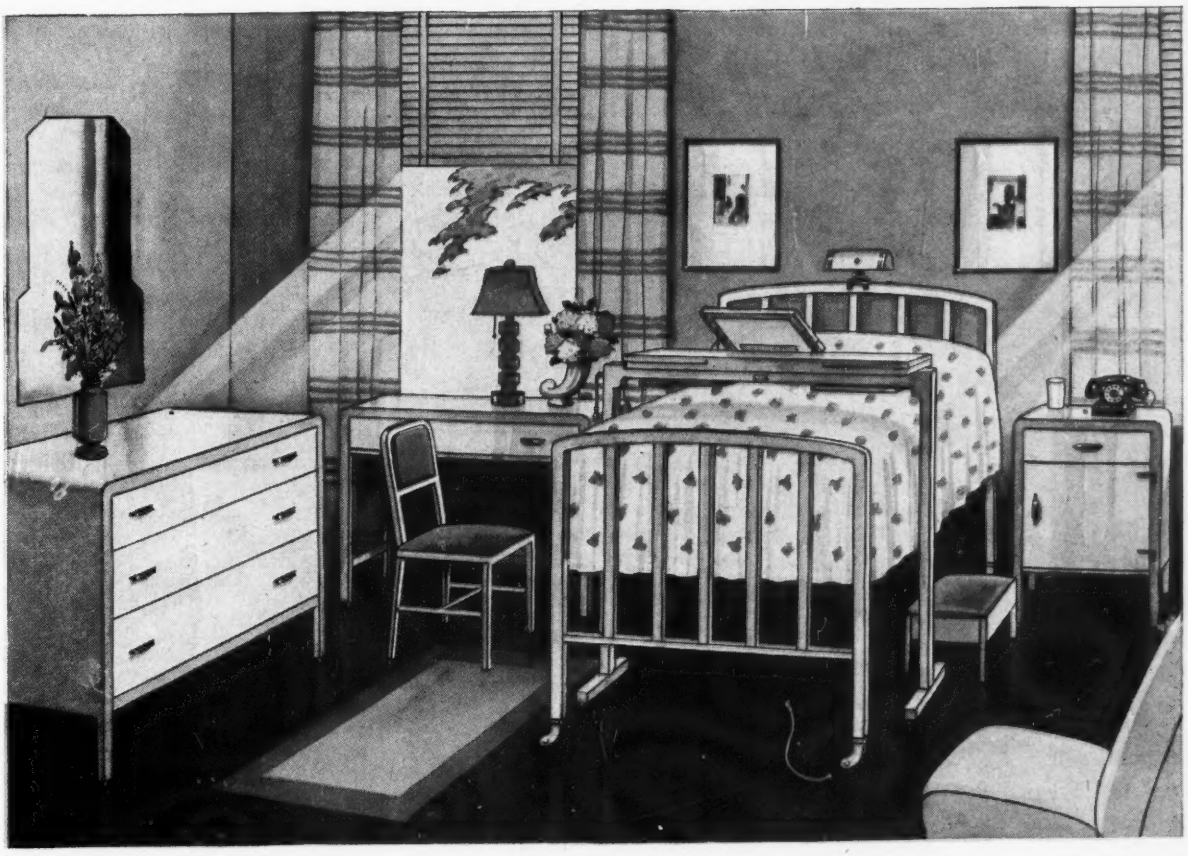

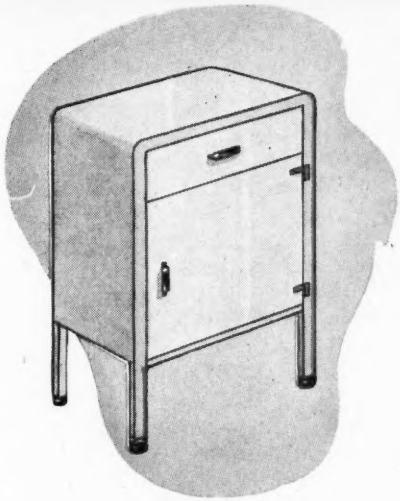

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C. E. A. Bedwell

Dear Mr. Editor:

The fine page of illustrations in your August issue and your own distinguished place in it are evidence of the lively interest taken in works of art. It stimulated me to obtain some particulars of a development which is taking place in this country in that connection, though I must admit that it is a form of activity in which I have no personal skill nor particular knowledge.

In the recently issued report of the National Association for the Prevention of Tuberculosis there is a paragraph devoted to the subject of art therapy in which it is recorded that sketching and drawing competitions are now held in some thirty sanatoria. "Patients who show an interest are suitably coached and trained and out of this an important movement, curative in its aims, is growing." Then the report goes on to state that it will not apply to all tuberculous patients and refers in particular to the "substantial minority" who can be interested in this way.

The point of view thus expressed differs somewhat from that of Mr. Adrian Hill who is one of the principal exponents of the value of art as a therapeutic agent. In a most interesting little book, published three years ago, with the title *Art Versus Illness* he set forth the history of his interest in the subject and the methods to be adopted in teaching patients. The principal scene of his activities has been Midhurst sanatorium which bears the name of King Edward VII and is under the administration of a body of trustees. An afternoon spent there with Mr. Hill was a revelation. Mr. Hill maintains that the average man has a natural artistic instinct and only needs a little encouragement to express it. To him the "substantial minority" of the Association is a quite definite majority. I visited one patient after another who assured me that, until they came into the sanatorium, they had no inclination to paint or do anything of the kind. They had been surprised by the discovery of a latent ability and obviously that must necessarily have a valuable effect upon their state of health. In more than one case among the group seen just on that afternoon there was evidence of a very definite improvement which could be attributed to this particular activity. The personal factor of Mr. Hill's own enthusiasm is the basis of the whole work and it must inevitably occur to any observer to wonder whether there might not be an equal effect if he inspired them to undertake some completely different occupation.

Art Therapy in Hospitals

Any impression of that kind was neutralised by a visit to a sanatorium of quite a different character under entirely different auspices. At one of the sanatoria of the City of Birmingham at Yardley there has just been appointed a whole time art therapist as a member of the staff of the occupational therapy department. This is believed to be a unique departure in this country, as the work at Midhurst and in other places has been done on a voluntary basis within the consequential limits of time and opportunity.

At Yardley the therapist has received her training in the school of Madame Segal, whose husband came to this country from the Continent before the War. The principles upon which his work is based were published in two small monographs. The first appeared in 1939 with the title *Art as a Test of Normality and its Application for Therapeutical Purposes* and the second was a lecture entitled *Art and Psychotherapy* published by the Guild of Pastoral Psychology in 1942. Mr. Segal has since died but his widow, in continuing his work, hopes that it may be possible to publish something more extensive from the material which has been left behind. These two publications are sufficient to show that he was very much concerned with the psychological effect upon the patient. It seems as if the occupation may operate in two ways. It may be a form of treatment in the sense that it has a soothing effect upon the mind in the same way as physiotherapy may affect the body. In other cases it acts as an outlet to dormant fears and distresses. The work produced seems to show definite evidence of that on some occasions.

The main problem which presents itself is whether art can claim to have greater merits than other forms of occupational therapy in contributing to the health of the patient. One man said that after some months he had become completely bored by reading and the art lessons were a great relief to him. Another said that he preferred the painting to needlework as it did not require so much patience and that naturally raised a doubt whether it was so beneficial to him.

The psychological effect of painting seems to be more marked than that of some other occupations and seems to raise the whole subject on to a higher level, where it will need to be taken much more seriously from the medical point of view. These occupations are pleasant forms of recreation in a general sense, but should their therapeutic value form the subject of scientific investigation? There is a movement in that direction and it may be that this new appointment marks the opening of an era.

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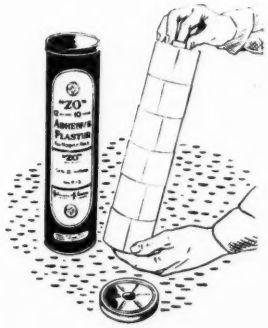

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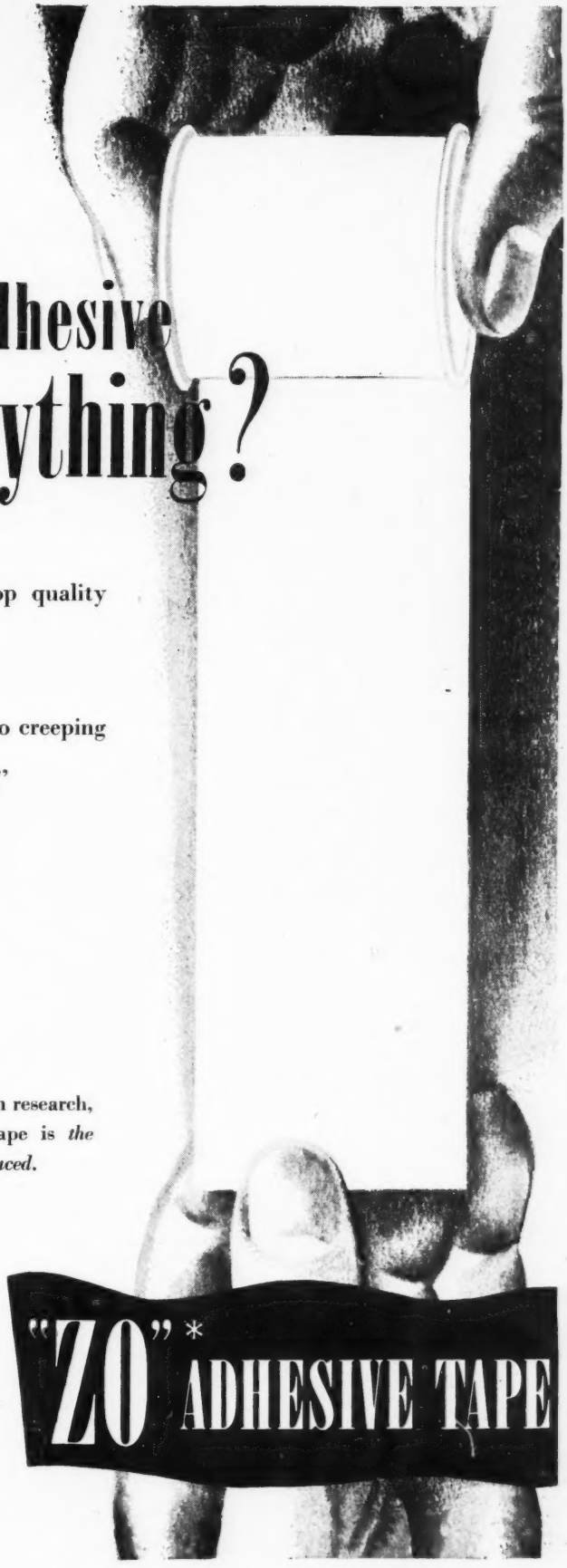


May a Nurse Sign a Death Certificate?

A REQUEST has come to us for information as to the conditions, if any, under which a registered nurse may pronounce a person dead. It is presumed that this problem might arise in a remote district where there is a nurse but not a medical man, or where there is an isolated practitioner whose territory and practice is so large that he cannot personally investigate every death in the area. It is conceivable, too, that in some nursing stations and outpost hospitals, there may be either no doctor available at the time or the lone doctor may be engaged elsewhere when the death occurs in the hospital.

Realizing that this question might be of wide interest to the health field and having no definite information on the subject, we have written to the deputy attorney-general of each province asking for comments and a statement of any regulations pertaining thereto. The information supplied to us is here set forth.

Prince Edward Island

". . . I must advise you that in this Province there is no authority under which a registered nurse may pronounce a person dead. The situation here owing to our shorter distances is such that it is always possible to obtain a physician for such purpose."

—F. A. Large, Attorney General.

Nova Scotia

". . . I take it that your inquiry has reference to whether a registered nurse, in the absence of a doctor, can give the necessary evidence on which a death certificate may be issued. If such is the case, Section 44 of the Vital Statistics Act, which is Chapter 3 of the Acts of Nova Scotia, 1946, provides:

'In case of any death occurring without medical attendance the Division Registrar is authorized to prepare and sign a certificate hereinbefore provided for from the statements of relatives or other persons having adequate knowledge of the fact; and any coroner who holds an inquest on the body of any deceased person and makes the Certificate of Death required for a burial permit, shall state on his certificate, if possible, the name of the disease causing death, or, if caused by violence, the probable means of death, whether accidental, suicidal or homicidal, as determined by the inquest, and shall, in either case, furnish such information as may be required by the Registrar properly to classify death.'

"This section would permit a registered nurse, in the absence of a doctor, who has adequate knowledge of the facts of the death, to give the information on which a death certificate is based."

—T. D. MacDonald, Deputy Attorney General.

New Brunswick

"Under the statutes of New Brunswick, no person may be buried without a burial certificate. Burial certificates are issued by the Sub-Deputy Registrars upon certificate of a physician. If no physician is available, the form is completed by some person having knowledge of the facts. Registered nurses, as such, have no statutory authority in this regard."

—J. Edward Hughes, Counsel, Department of the Attorney General.

Quebec

The Quebec Public Health Act, section 141, supplied by the Assistant Deputy Attorney General contains the following statement:

"If it be impossible to obtain the certificate of the attending physician, or if no physician has been called in, the medical part of the certificate shall be signed by the coroner, or by a justice of the peace, whenever the deceased resided during his last illness less than five miles from the nearest physician; but if such distance be five miles or more, the medical part of the certificate may be signed by the coroner or justice of the peace or by a clergyman, or by two credible persons, who shall state, to the best of their knowledge and belief, the cause of death."

Ontario

"In my opinion the suggestion that nurses might be given authority to pronounce a person dead should not be too readily entertained. In the past ten years I cannot recall a case where any undue delay was occasioned by reason of a medical practitioner or coroner not being available. To meet a situation that might arise in some remote area, particularly northern Ontario, there is a provision in the Coroners Act (Statutes of Ontario 1946, chapter 14) which is as follows:

'In the case of a death occurring in a provisional judicial district or a provisional county at a place which, having regard to the distances involved or to transportation facilities or other circumstances, is difficult or inconvenient for a coroner to reach, a coroner who has issued his warrant to take possession of the body may authorize and direct a duly qualified medical practitioner, magistrate or member of the Ontario Provincial Police Force to take possession of the body, view the body and make such further inquiry as may be required to determine whether or not an inquest is necessary and to report to him.'

In a provisional judicial district it might also be noted that a Magistrate may at the request of the Crown act as a coroner. I must therefore express an opinion that there seems to be no necessity in Ontario to give a nurse authority to pronounce a person dead."

—C. L. Snyder, K.C., Deputy Attorney General.

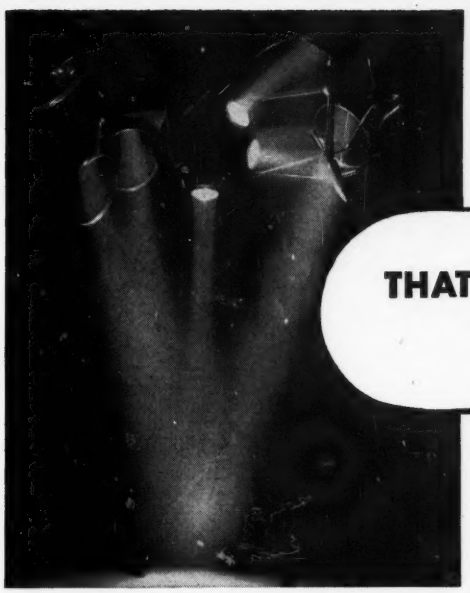
Manitoba

The following paragraphs from the Vital Statistics Act of Manitoba, a copy of which has been supplied to us by the Deputy Attorney General of that province, would seem to cover the question:

"In case of any death occurring without medical attendance, it shall be the duty of the undertaker or other person who has charge of the burial or removal of the body to notify the division registrar of the death, and when so notified the division registrar shall inform the local health officer and refer the case to him for immediate investigation and certification, prior to issuing the permit.

"Where the local health officer is not a qualified physician, or where there is no such official, and in those cases only, the division registrar is authorized to prepare and sign a certificate to take the place of the medical certificate from the statement of relatives or other persons having adequate knowledge of the facts."

(Concluded on page 80)



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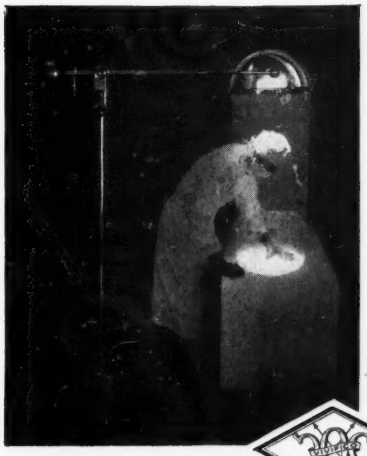

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Recommendations to Minimize Electrical Hazards in Operating Rooms

THE Canadian Standards Association has issued the fifth edition of the *Canadian Electrical Code, Part I*, a comprehensive volume dealing in detail with a wide range of installation requirements in all kinds of buildings. Of particular interest to hospitals is *Appendix B* (pp. 273-280) which deals with electrical wiring and equipment in hospital operating rooms.

A special committee of the C.S.A. dealing with this subject has been assisted over the past two years by a committee of the Canadian Hospital Council under Dr. W. R. Feasby, and a Canadian Medical Association committee under the chairmanship of Dr. H. J. Shields. Although agreeing fully with the desirability of conforming to the rigid requirements of the Code, these sub-committees did not desire that these requirements be made mandatory, in view of the excessive cost of complying with all of the clauses and the relative infrequency of accidents under present conditions. Accordingly, for the present, it was agreed that this particular section should not appear in the body of the Code as essential requirements and minimum standards, but should be included as *Appendix B*, with a strong recommendation for its adoption.

The electrical departments in some of the provinces are strongly of the opinion that efforts should be made to bring these requirements into mandatory status. The inspection authorities are anxious to have some provision for installing new equipment in a proper manner in the interests of public safety. It is not obligatory to change existing installations nor might it become so should the requirements become mandatory, but it is expected that where alterations and renovations are concerned proper installations will be introduced.

APPENDIX B

Electrical Wiring and Equipment in Hospital Operating Rooms

Recommendations for electrical wiring and equipment to be used in operating rooms, delivery rooms, and similar places are given in this Appendix.

In the above mentioned hazardous locations, all installations and equipment should be in conformity with the requirements for Class I, Group C, locations given in Section 32, of the Canadian Electrical Code. All references to the Canadian Electrical Code are to the 1947 edition.

In locations of limited hazard, permanent wiring and equipment should conform to the standards of the Code applying to non-hazardous locations. Portable electrical equipment and appliances, unless of a type suitable for use in hazardous locations, should be excluded from locations of limited hazard during their occupancy by patients or by anaesthesia equipment in an operating condition.

Note: *Hazardous Locations*—as applied to this Appendix mean a room in which any of the hydrocarbon anaesthetic gases or any of the ether compounds are stored or used. The hazardous condition may be considered as extending for a horizontal distance of 10 ft. and to a height of 7 ft. above the floor outside of any door opening into such a room.

An exception may be made in the case of a room ventilated as specified under "Ventilation" (at the end of this Appendix); in such rooms the hazardous condition may be considered as extending to a height of 7 ft. above the floor.

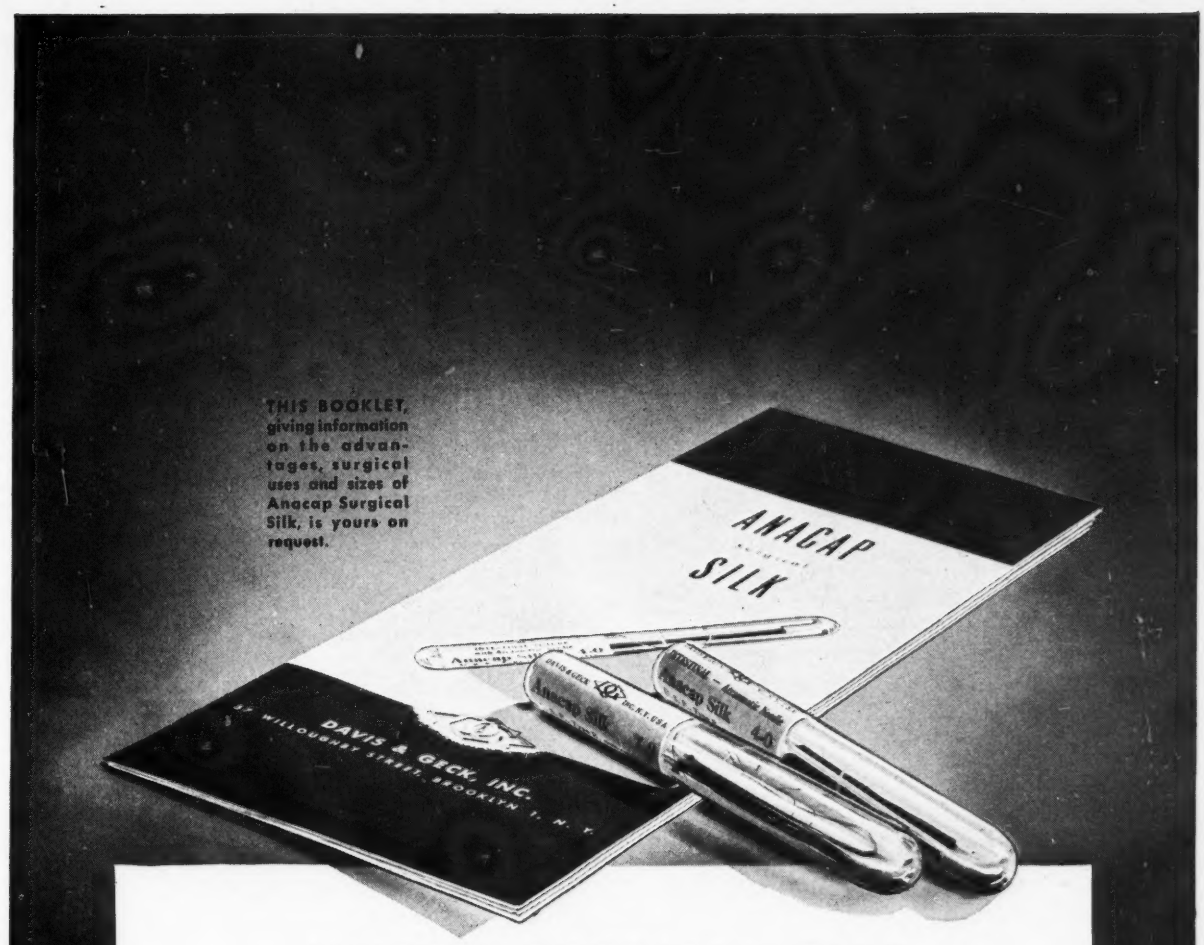
***Locations of Limited Hazard*—as applied to this appendix mean any corridor or room through which a patient is moved during the progress of anaesthesia, or through which anaesthesia equipment is moved while in an operating condition. In such locations hazards due to permanently installed electrical equipment should be considered as being the same as for non-hazardous locations; hazards due to electrostatic charges should be considered as being the same as for hazardous locations.**

In non-hazardous locations all electrical wiring and equipment should conform to the standards of the Code applying to such locations.

Arrangement of Circuits

In hazardous locations all electrical circuits should be fed by an insulating transformer which isolates them electrically from the main feeder and from other circuits in the building. This transformer should be of the dry type and should be installed outside the hazardous location. It may be considered as a special form of branch feeder. The primary winding should be connected to the main feeder, in the same manner, and with the same control and protective devices, as any other branch feeder of the electrical installation. One side of the primary circuit should be grounded in an approved manner and the other side provided with an approved overcurrent device located outside the hazardous location. The primary winding should never be connected directly to a high potential circuit. Both sides of the secondary circuit should be ungrounded and an approved overcurrent device should be provided in each side of every branch circuit connected thereto. Voltages across the ungrounded circuits should not exceed 115 volts.

In addition to the usual control and protective devices the ungrounded system should be provided with a ground contact indicator arranged as follows: A resistor of not less than 10,000 ohms should be connected across the secondary circuit of the transformer. A relay, installed outside the hazardous location, should be connected with its winding between the mid-point of



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this resistor and ground. The relay should operate when either side of the secondary circuit is connected to ground.* A signal lamp showing a green colour, installed in some conspicuous location, should be connected to the back contact of the relay so that it shall be lighted when no current flows through the relay winding. A signal lamp showing a red colour, installed adjacent to the green lamp, should be connected to the front contact of the relay so that it shall be lighted when current flows through the relay winding. Warning is thus given of any connection between either side of the secondary circuit and ground and, hence, of any hazardous defect in any wiring or equipment connected thereto.

Service Equipment

All service equipment, switchboards, or panelboards should be installed in a non-hazardous location.

Overcurrent Devices

All overcurrent and other protective devices should be installed in a non-hazardous location.

Wiring Method

In any location all permanently installed electrical wiring should be enclosed in a rigid conduit which is grounded in an approved manner. All wiring should be installed as specified for Class 1 locations in Section 32 of the Canadian Electrical Code. Special attention should be given to sealing the conduits in accordance with the requirements for Class 1 locations.

Grounding

In any location, the exposed non-current-carrying metal parts of equipment such as the frames of metal exteriors of motors, fixed or portable lamps or appliances, fixtures, cabinets, cases and conduit should be grounded as provided in Section 9 of the Canadian Electrical Code. The locknut-bushing, and the double locknut types of contact should not be depended upon for bonding purposes, but bonding jumpers with proper fittings or other approved means should be used. All grounding should be as specified in Section 32, of the Canadian Electrical Code.

Lighting Fixtures

In hazardous locations, in accordance with the requirements of the Canadian Electrical Code, Section 32, lamps in fixed position should be enclosed in a manner approved for use in explosive atmospheres, and should be properly protected by substantial metal guards or other means where exposed to breakage. Lamps should not be of the pendant type unless supported by and supplied through hangers of rigid conduit or flexible connectors approved for use in explosive atmospheres. Conductors should have a thickness of insulation not less than 3/64 inch for rubber or 1/32 inch for thermoplastic. Rigidly mounted fixtures should be strongly supported.

Exceptions may be made, as follows, provided the room is adequately ventilated by mechanical means. (For requirements for adequate ventilation see paragraph headed "ventilation" at the end of this Appendix):

(a) In the case of permanently mounted lamps, either fixed or adjustable, which are so constructed and so located that no part may be brought within 7 ft. of the floor.

(b) In the case of lamps mounted in or behind the walls in housings ventilated independently of the atmosphere of the room and from which this atmosphere is excluded by substantial vapour-tight glass windows, no portion of which is within 5 ft. of the floor, approximately flush with the wall. It is recommended that lamps be replaceable from outside the room so as to avoid disturbing the vapour-tight seal of the glass window.

Lighting Switches

In hazardous locations, in accordance with the requirements of the Canadian Electrical Code, Section 32, switches controlling lighting circuits should be of a type approved for use in Class 1, Group C locations.

Such switches should be of the double-pole type and should open both sides of the ungrounded circuits which they control. Attention is called to the fact that mercury type switches, although producing no exposed spark on operation, when in normal condition, are not approved by the Canadian Standards Association for use in explosive atmospheres unless enclosed in explosion-proof housings.

Receptacles and Attachment Plugs

In hazardous locations, in accordance with the requirements of the Canadian Electrical Code, Section 32, receptacles and attachment plugs should be so connected, as part of a unit device with an explosion-proof interlocking switch, that the plug cannot be removed while the switch is in the "on", position, or approved devices in which the circuit is broken in an explosion-proof enclosure should be used. Such receptacles and plugs should be of the polarized type which provides a connection for the grounding conductor of the flexible cord.

Flexible Cord

In hazardous locations, in accordance with the requirements of the Canadian Electrical Code, Section 32, flexible cord for portable lamps or portable electrical appliances should be of a type designated for hard usage, such as Type S. Such flexible cord should contain one extra insulated conductor to form a grounding connection for metal lamp guards, motor frames, and all other exposed metal portions of portable lamps and appliances. The outer covering of this grounding conductor should be finished to show a green colour. Portable cords connected directly to supply conductors should be securely supported so that the probability of a break in the conductors at this point should be minimized.

Portable Lamps

In hazardous locations, in accordance with the requirements of the Canadian Electrical Code, Section 32, portable lamps should be enclosed in a manner approved for explosive atmospheres and should be protected against breakage by approved types of guards. Lampholders for such portable lamps should be of moulded composition or other approved material and of the keyless type with no exposed metal parts. Portable lamps in hazardous locations should not be equipped with switches. Current should be turned

** For a given value of resistance across the secondary circuit the relay will receive maximum power when the impedance of its winding is equal to ¼ of this value. The voltage across the relay winding in this case will be ¼ of that across the secondary circuit.*

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on or off at an explosion-proof outlet receptacle.

Motors

In hazardous locations, in accordance with the requirements of the Canadian Electrical Code, Section 32, motors and generators should be of a type approved for use in Class 1, Group C locations.

Belting

In any location, all belting used in connection with rotating machinery should have incorporated in it sufficient conductive material to prevent the development of electrostatic charges. A conductive pulley should be used. The conductivity of the path from the pulley to the ground should be considered. If ball bearings are used, the contact between the balls and the races will probably be sufficient. If sleeve bearings are used, some means of conducting the charge from the pulley should be provided.

Control Devices

In hazardous locations, in accordance with the requirements of the Canadian Electrical Code, Section 32, devices or apparatus, such as motor controllers, thermal cut-outs, switches, relays, the switches and contactors of auto-transformer starters resistance and impedance devices, which tend to create arcs, sparks, or high temperatures, should not be installed unless such devices or apparatus are of a type approved for use in Class 1, Group C locations.

It is recommended that such devices be installed in a non-hazardous location and actuated by some suitable mechanical, hydraulic, or other non-electrical remote control device which may be operated from any desired location. This applies particularly to foot and other switches which must be operated from a location at or near the floor.

Suction and Pressure Equipment

In any location suction apparatus should be of the aspirator type, driven either by compressed air or by water jet. Where necessary to use motors for driving the pumps of suction, pressure, or insufflation equipment, whether of the unit type or of a type having a common pump installed outside a hazardous location, they should be of a type approved for use in Class 1, Group C locations. The pumping equipment and any non-electrical auxiliaries would be of a type approved for use with explosive vapours.

With all suction apparatus, means should be provided for liberating the exhaust gases in a location where they shall be effectively dispersed without coming in contact with a possible source of ignition.

Low Voltage Circuits

In any location, all electrical apparatus or equipment having exposed current-carrying elements or which is frequently in contact with the bodies of persons, should be of a type operating on a voltage of not over 6 volts. Power may be supplied to such apparatus or equipment from individual transformers connected to an outlet receptacle by means of a plug and cord of types approved for use in Class 1, Group C locations or by a common transformer installed in a non-hazardous location. Transformers for supplying low voltage circuits should have approved means for insulating the secondary circuit from the primary circuit and should have cores and cases grounded in an approved manner.

Power may also be supplied to low voltage circuits from individual batteries made up of dry cells or from common batteries made up of storage cells installed in a non-hazardous location.

Any receptacle or attachment plug used on low voltage circuits should be of a type which does not permit interchangeable connection with circuits of higher voltage. Exposed non-current-carrying metal parts of electrical equipment or apparatus operating on voltages of 6 volts or less should not be grounded.

It should be recognized that any interruption of the circuit, even circuits as low as 6 volts, either by any switch or loose or defective connections anywhere in the circuit, may produce a spark sufficient to ignite combustible gases.

Cautery Equipment

All hot-wire cautery apparatus should be operated on voltages of 6 volts or less. *Note: Great caution should be taken in operating cautery equipment in hazardous locations.*

Illuminating Instruments

In any location, all instruments for providing electrical illumination which are brought into close contact with the bodies of persons, such as endoscopic instruments, head lamps, and the like, should be operated at voltages of 6 volts or less. Switches and control devices for such instruments should be operated at a distance of at least 3 ft. from any portion of any system containing mixtures of explosive gases.

Diathermy and X-ray Equipment

Diathermy and x-ray equipment should be provided with an approved form of grounded electrostatic shield. All switches and control devices for diathermy and x-ray equipment should be operated outside the hazardous location.

Signaling Systems

In hazardous locations, in accordance with the requirements of the Canadian Electrical Code, Section 32, all equipment of signaling and communication systems, irrespective of voltage, should be of a type approved for use in Class I, Group C locations. All wiring for such systems should be installed in accordance with the requirements for Class 1, Group C locations.

Ventilation

Method of Ventilation

All hazardous locations as defined in this Appendix should be ventilated by mechanical means. Air should be brought into the room by ducts opening not less than 6 ft. from the floor and removed from the room by ducts opening not more than 3 ft. from the floor and at least one duct at the ceiling.

Amount of Ventilation

There should be a change of air of not less than 20 cu. ft. per person per minute, but in no case should there be less than 12 changes of air per hour.

Arrangement of Equipment

The preferable location for the circulating fans or blowers is in the inlet ducts.* Regardless of location, fans should be of a type approved

(Concluded on page 82)

**Vapours in the inlet ducts are less likely to be flammable than those in the outlet ducts. The use of fans in the inlet ducts also maintains a positive pressure in the operating room, thus tending to lessen air-borne infection brought in from corridors and other adjoining locations.*

Book Reviews

ON HOSPITALS. A collection of papers by the late Sigismund S. Goldwater. Illustrated. Pp. 392. Price $9.00. The Macmillan Company, Toronto, 1947.

The hospital field is well aware of the tremendous contribution of Dr. Goldwater to the hospital of to-day. From the time he became director of Mount Sinai Hospital in New York City in 1902 until his death forty years later, Dr. Goldwater was one of the great hospital figures of this century. For many years the leading hospital consultant on this continent, his services were in great demand as an adviser in re-organization and in hospital planning. The present highly efficient setup of the American Hospital Association with its array of active Councils was conceived by Dr. Goldwater back in the 30's when he became initial chairman of the present Councils' antecedent, the Council on Community Relations and Administrative Practice. He, too, was really the man who made possible the first International Hospital Congress at Atlantic City in 1929.

It was fitting that his many papers should be reviewed and a selection made for inclusion in this volume. A prolific writer, yet a meticulous one, he wrote on a wide range of hospital topics—organization, professional relations, community relations, administrative detail, the hospital future, hospital psychology and, a major interest, hospital planning and design. The plans of a number of hospitals, for which he was largely responsible, are described and illustrated in the closing chapters.

The reader will find much of value in this volume, material which cannot be dated, for it is as sound to-day as the day it was written. Dr. Goldwater not only had ideas but he could express them in a pithy and delightful manner. This volume will make excellent reading for the administrator and the trustee.

CAMERA ART as a Means of Self-Expression. By Max Thorek, M.D., F.R.P.S., F.R.S.A. With 41 original illustrations by the author. Pp. 246. $5.00 (U.S.A.) J. B. Lippincott Co., Philadelphia and New York, 1947.

Dr. Max Thorek is one of those amazing personalities who lives in two worlds and has achieved international recognition in both. Professor of Surgery at the Cook County Graduate School of Medicine and Secretary of the International College of Surgeons, he has written many textbooks and reference works on surgery. As Fellow or Past-president of several photographic and art organizations and winner of almost innumerable awards, he has become an acknowledged leader in the field of photography.

This book is mainly one of personal views and experiences. It is not designed to teach the rudiments of photography but rather to pass on to the student of photography many of the ideas of technique and composition which the author has gained through years of experimentation and study. An exponent of personal expressions through "control methods" of modifying the negative, Dr. Thorek favours the paper negative process as a means of obtaining more dramatic effects than otherwise would be possible. There are chapters dealing with lighting, enlarging, portraiture, outdoor pictorial photography and other topics of interest. The plates are particularly interesting.

* * * *

V.O.N. By Murray Gibbon, author of *Three Centuries of Canadian Nursing*. Printed by Southam Publishing Company for the Victorian Order of Nurses for Canada, 114 Wellington Street, Ottawa. Pp. 124. Price $2.00.

The publication of V.O.N. this year marks the fiftieth anniversary of the Victorian Order of Nurses for Canada. Well documented with letters, newspaper reports, and accounts of the experiences of courageous nurses who pioneered in their field, this book presents a dramatic story of development, despite grave hardship, in remote corners of the Dominion over the turn of the century. .

Full credit is given to the founders of this organization, whose vision, determination and perseverence, nurtured the Victorian Order of Nurses through the many trials of its early years, and who grasped every opportunity to build upon its successes. The reader is also given intimate glimpses of the heated controversy which ensued, both in professional circles and among politicians, when the idea of such an organization was conceived.

In 1922, a survey of District Nursing disclosed that the Victorian Order of Nurses was then engaged in sixteen broad activities in Canada. Description of these activities is given in the book. In the closing pages the author has tabulated the growth of the Order since its inception, and has made available the names of all officers from the year 1898 to the present day.

* * * *

LABORATORY MANUAL OF MICROBIOLOGY FOR NURSES. By Elizabeth S. Gill, B.S., R.N., Instructor in Nursing, Department of Nursing, College of Physicians and Surgeons, Columbia University, New York; and James T. Culbertson, Ph.D., Professor of Bacteriology and Parasitology, University of Arkansas School of Medicine, Little Rock, Arkansas. Pp. 116. $1.50. G. P. Putnam's Sons, 2 West 45th St., New York City.

This practical laboratory workbook is designed for the student nurse. Charts and data are included with chapters on the following: Use and Care of the Microscope; Staining of Bacteria; Examination of Bacteria for Motility; Preparation of Bacteriological Culture Media; Inoculation of Culture Media; Cultivation of Bacteria from the Environment and from the Healthy Body; Sterilization, Disinfection and Antisepsis; Staphylococci; Streptococci; Pneumococci; Neisseriae; Enteric Bacteria; Corynebacteria; Mycobacteria; Spore-forming Bacteria; Spirochetes; Yeasts and Molds; and Protozoans, Helminths and Arthropods. Each section is followed by exercises and questions for the student. Appendices at the end of the book cover reagents and solutions, and a listing of sources of materials.

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The Internship

(From "Medical Education and the Changing Order" by Raymond Allen, M.D., Ph.D., one of the series of studies by the New York Academy of Medicine's Committee on Medicine and the Changing Order. The Commonwealth Fund.)

THE medical student begins to look forward to his internship and to plan for it almost as soon as he is introduced to clinical work in the hospital. There he observes that the intern is a fairly important person, sharing responsibility with his elders for the care of patients. The intern is not burdened with a schedule of classes and the prospect of formal examinations. He is accepted and respected by the doctors and the nurses, particularly by student nurses. As an undergraduate, he was in the self-effacing position of a classroom and laboratory student and clinical clerk; as an intern, he takes a long step toward the professional position and bearing of a physician.

What does the hospital offer him in the way of further opportunities to study and to learn medicine? First and foremost it affords an ideal opportunity for him to apply and develop his knowledge and skill in diagnosis and treatment under the watchful eyes of experienced physicians. Thus he takes another carefully supervised step toward independent responsibility for the life and welfare of patients. It is this kind of experience for which the eager student of medicine has been striving ever since he decided to become a physician. If his undergraduate education has been sound and inspiring, and if during his internship he has the good fortune to come under the influence of good clinicians who like to teach, a vital educational experience is assured. In the absence of either of these elements, that is, an eager, well-educated student and an experienced clinician who enjoys working with students, any amount of organization, rules and regulations, required lectures and seminars, reports and grades will fall far short of anything like the ideal.

There is little doubt that some internships fail even to approach such an ideal. The fault lies with medical schools which select students poorly adapted to medicine and then fail to provide an adequate medical education, and with hospitals which do not recognize that the internship is an important, indeed critical, part of their responsibility to patients and to the whole educational process. Hospitals which fail to perceive their role in medical education and think that they have discharged their obligations to the intern by providing suitable living quarters, recreational facilities, perhaps a small stipend (in general, the poorer the internship the larger the stipend), an opportunity to write histories and do physicals, make hurried rounds with a busy practitioner, hold retractors at operations, and carry out other routine functions—these have no place in any plan of genuine internship education. The spread between high-quality educational internships and those which merely satisfy formal, so-called minimum, requirements is very wide indeed. A regrettable aspect of the whole situation is that the weaker students often have no alternative but to take the poorer internships, thus further complicating an already difficult educational problem. The internship experience should strengthen, not weaken, the student's appreciation of high scientific and ethical standards of practice. The quality of staff and interns determines the quality of internship, just as the quality of faculty and students determines the quality of an undergraduate teaching program.

Considerations such as these have led medical schools to give serious thought to requiring the internship as a fifth year for the degree of Doctor of Medicine. A few pioneer schools, beginning with Minnesota in 1910, have had this requirement for many years, but unless all schools co-operate in such a plan, it is doubtful whether it will have the desired influence on standards of internship education generally. Hospitals are not primarily educational institutions; they exist to serve the needs of patients. But they should recognize their educational functions and should realize that the better the interns' education the better the service to patients. Medical schools should take the initiative in all matters which affect the needs of medical education, and certainly the educational problems of the internship need vigorous attention now.

With the adoption of standards of qualifications for the practice of the clinical specialties requiring advanced graduate training, the internship is evolving as a basic general discipline in medicine which should serve as a foundation for training in a specialty or for the practice of general medicine. In an earlier day, the internship was often prolonged to provide specialized training and was sometimes limited, even during the first year, to the specialty of internal medicine or of general surgery—the so-called "straight" internship. At the other extreme were the "rotating" internships, which endeavoured to provide training in every clinical specialty, presumably on the theory that a general practitioner should have a smattering of technical training and experience in all branches of clinical medicine. Gradually it has become evident that rotating internships were degenerating into a merry-go-round of kaleidoscopic impressions of medical practice with undue emphasis on its technical aspects, and it is now generally recognized that the internship should be concerned primarily with the study of patients as persons, the natural history of their diseases, and the appropriate regimens of treatment. With the patient as the unit of study, the internship is gradually being reoriented and rearranged so that interns can broaden and deepen their knowledge of men by studying them intensively when they are sick.

Of the traditional hospital services, those which are best able to offer this type of experience and training are general medicine, paediatrics, obstetrics, general surgery including anaesthesiology, and neuropsychiatry. The surgical specialties, on the other hand, attract many interns because they offer opportunities to learn technical operative procedures. The intern should have an opportunity to follow his patients through special diagnostic and treatment clinics and

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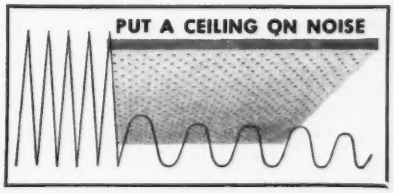

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help with their care, but no specific block of time should be set aside for service exclusively in a surgical specialty. The internship, in other words, is becoming organized around the subject matter of study which is the patient rather than around artificial subdivisions of hospital service to suit the convenience of the hospital. Such an internship, it is to be hoped, will eventually become an experience in community family practice in which the intern, as though he were the family doctor, will be responsible for studying an assigned patient from the time of first admission to the hospital or the outpatient department through his entire illness. He will write the history, make the initial examination, do some of the laboratory work, keep accurate records, assist with technical procedures and do the minor ones himself, be present at all consultations, investigate conditions in the home or working place which may constribute to a better understanding of the case, and follow up his patient after discharge from time to time as indicated by the particular circumstances of the case. In short, the intern should be as close to the patient as the attending physician himself, and the latter, if he is a teacher at heart, should welcome, not resent, the interested collaboration of his young assistant. Too frequently the first and last time a private patient is seen by the intern is when the history is taken or when an operation is performed. Any hospital, public or private, which makes a serious effort to create an educational atmosphere for internship training will not tolerate such slovenly professional habits.

Properly conceived and organized, the internship can be greatly strengthened as a discipline in both the science and the art of medicine, either in preparation for general practice or as a foundation for further training in a clinical specialty. If the intern has the temperament of a physician, a thorough education in the liberal arts and sciences, and a medical education which has stimulated his curiosity and intelligence, there need be little concern about how he employs his time. He will always be found where there is something for him to do and to learn. Opportunities to discuss cases and medical literature and to receive constructive suggestions and criticism should be provided both informally and in formal conferences, seminars and staff meetings.

The internship, like undergraduate medical education of which it is really a part, is almost entirely concerned with curative medicine. Increasingly, however, people are becoming health-conscious. They are aware that preventive medicine can contribute to healthful living, and they realize that a state of positive health is something to be prized and sustained always. Naturally they turn to the doctor for advice. Nevertheless, many medical schools have yet to introduce at any level, including the internship, a well-integrated effective teaching program which will adequately foster education and modern viewpoints concerning the value of full and positive health and of preventive medicine. Preventive medicine is concerned with the prevention of disease; and it embraces a rapidly growing body of known and certain facts and techniques. Increasingly, medical science is bringing into view more of the facts which support broad theories of the causation of disease and disability generally. As this knowledge extends, its corollary is that the ways in which such disability and disease *may be prevented* become evident. Knowledge of the effects of the complexities of modern life on the individual points to the preventive measures which should be instituted. Likewise, study of the nature of the life process brings information of value in understanding how a person instinctively and consciously reacts to protect himself from untoward environmental influences. It is this larger concept of medicine and its place in the culture of the times which will emerge as more knowledge accumulates and becomes reflected increasingly in medical education and in general health education programs for everyone.

The internship should be so organized as to provide unrestricted opportunities for the wide-awake young physician to learn how to correct disabilities which cause patients to come to doctors and how to prevent such disabilities by discovering their predisposing and immediate causes both in the patient himself and in his surroundings. When this can be accomplished as a full discipline in community medicine in all its many ramifications through public and private agencies, preventive medicine and public health will be truly integrated in medical education.* The internship will then become an experience in the practice of preventive as well as of curative medicine, in community family medicine as well as in hospital and outpatient department medicine. What could be a better foundation for either the general practice of family medicine or for training in a clinical specialty?

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* *Undergraduate medical education and the internship should provide opportunities for introduction to and, when possible, participation in the activities not only of industrial health clinics, public health departments and laboratories, community health centres, maternal and infant welfare and prenatal clinics, services for crippled children, medical welfare agencies, and group clinics, but also of general practitioners and specialists in private practice, both urban and rural.*

Rebuff for British Nursing

The British Journal of Nursing reports that the Registered Nurses' Association of British Columbia has cancelled the existing agreement for reciprocal registration of nurses. The British Columbia body avers that nursing education in England, both in respect of educational qualifications and training itself, falls below that of British Columbia, and that they have taken the step "in fairness to members of the nursing profession in British Columbia". It is admitted in the *British Journal* that educational standards for entry into training schools are higher in North America, and that the curricula in nursing schools there are more academic and more widely-embracing. It points out, however, that the minimum standard and minimum number of lectures laid down for students in England represent an absolute deadline, and that in practice students receive many more lectures and tutorials. Somewhat alarmed, the *Journal* asks if any other associations will follow the lead of British Columbia.

—From the South African Nursing Journal.

A hospital is not judged by the brilliance of its surgeons but by the quality of its medical records department. — Dr. John Hepburn.

Enemies of Hospital Linen

ONE of the biggest bugaboos to institutional laundries is damage to hospital linens. The hospital laundry is frequently blamed for chemical damage occurring in hospital fabrics, since the full extent of such damage generally shows up only when the articles are washed. In most cases when a hole appears, the laundry is blamed — is accused of using strong solutions in washing formulae. Actually *none of the products used in washing formulae, when applied in the manner prescribed by the manufacturers, could cause this damage.*

Many times the damage may be traced back to some circumstance of use to which the fabric had been subjected. Some medicines, antiseptics and germicidal agents injure fabrics, and many of the mysterious holes appearing in nurses' uniforms, hospital linen, doctors' coats and operating gowns are due to contact with these preparations. Many doctors, nurses and laboratory technicians are not aware that a few drops of some medicinal preparation spilled on the garment could have been responsible for the damage. Chemical damage, from spillage or from wiping the hands on the front of the gown, usually results in irregular shaped holes with ragged outlines, and a surrounding area which is weak and will tear easily. Often the hole is a nearly perfect circle, such as could be caused by some corrosive preparation on the bottom of a bottle which has rested on the fabric. Many of the medicinal and antiseptic preparations in common use in hospitals are so destructive that it is only necessary for cottons to come into contact with small amounts of the concentrated material for deterioration to occur; likewise damage may be caused through contact with dilute solutions of these materials if the solutions are allowed to dry out on the fabric. Then, when next the fabric is laundered, the greatly weakened damaged areas generally fall into holes under the mechanical action of the washing process.

A Test Is Conducted

Writing in *The Laundryman* recently, E. T. Cullen, laundry manager of the Salem Hospital (Salem, Mass.) tells of a simple test conducted to prove that this type of damage was not caused in his laundry:

"After my department had been charged for two nurses' uniforms and I had been asked to explain damage to linen, especially operating room linen, I decided to do something about it. I set out to determine what, if any, medicinal preparations, being used in the hospital, would cause damage to linen and uniforms. From the supervisors of operating room, laboratory, X-ray and pharmacy departments I obtained samples of the solutions used and from these I selected the following twelve as being the most likely to cause damage:

1. Formaldehyde solution
2. Chlorinated lime
3. Hydrogen peroxide, 3%
4. Bard Parker solution
5. Mercresin solution
6. Zephiran solution
7. Tincture of violet
8. Iodine, 3%
9. Potassium Permanganate
10. Potassium Dichromate
11. Writing ink
12. Silver nitrate, 20%

I then took a piece of sheeting, 18 x 24 inches in size, marked off twelve sections and applied several drops of the first solution in the first section, and followed with each of the other solutions in the succeeding sections of the cloth. Next, the test piece was put away for a period of two weeks to make sure that each solution had time to dry and concentrate.

The test piece was then placed in a net and washed twenty times with hospital linen, using our regular formula. (See chart.)

The Proof of the Pudding

After twenty washings the test piece was ironed and examined for chemical damage. A slight tendering and discoloration of some of the sections was visible to the naked eye. In the section which had been treated with potassium dichromate an actual hole appeared. This strong solution of chromic acid and potash was used in the laboratory for cleaning glassware.

Results of the test indicated conclusively that, as every hospital laundry manager knows, laboratory technicians are without doubt our toughest customers, so far as damaged uniforms are concerned. They also proved that other solutions used in the laboratory, operating room, X-ray, wards and many other departments, although not as strong as the potassium dichromate, could cause chemical damage.

I do think that every laundry manager should run a test similar to this one, in order to have something tangible to back up his arguments. Then, too, with his test piece before him, he can in many instances identify the agent which caused the original damage."

WASHING FORMULA

Operation	Water Level	Temperature	Time
1. Flush (optional)	12 inches	100 degrees F.	3 min.
2. Suds	5 "	120 "	10 "
3. Bleach and polyphosphate	5 "	160 "	10 "
4. Rinse	5 "	160 "	3 "
5. Rinse	12 "	160 "	3 "
6. Rinse	12 "	130 "	3 "
7. Sour	5 "	95 "	3 "
8. Blue	12 "	cold	5 "

Provincial Notes

Prince Edward Island

CHARLOTTETOWN. A new wing is being added to the Charlottetown hospital here. Citizens are solidly behind the fund raising campaign for this addition to the hospital which has acquired such a fine record of community service.

* * * *

MONTAGUE. The new King's County Memorial Hospital was officially opened in October. This structure embodies all the most up-to-date facilities of the modern hospital.

Nova Scotia

HALIFAX. It is expected that the new Victoria General Hospital wing will be officially opened by March 1st. This hospital's construction has been one of the major items on the agenda of the Public Works Department of this province.

* * * *

PUGWASH. The newly established North Cumberland Outpost hospital at Pugwash was officially opened early in November. Remodelled from a large home located about a mile from the village, this new institution is well equipped for hospital purposes.

New Brunswick

RIVERSIDE. A 15-bed hospital here, which has been closed for the past three years, is again in operation. It will serve residents of the three Albert County parishes of Hopewell, Harvey and Alma.

* * * *

SAINT JOHN. Negotiations between the city authorities, the National Harbors Board and the Canadian Pacific Railway here for an emergency hospital and ambulance service are nearly completed, according to a report by city councillor, James A. Whitebone. Known as the West Saint John emergency and hospital service, the unit will be located in a building donated by the Harbors Board and it is hoped that the Canadian Pacific Railway will operate this service. The city will take responsibility for equipment and renovation.

Quebec

NORANDA. It is expected that several floors of the extension to the Youville Hospital here will be in operation early in January. When completed, this hospital will have accommodation for 93 additional patients, nurses' residence, living quarters for nursing sisters, a cold storage plant and several new operating rooms.

Ontario

FORT ERIE. Board of Trustees of the Douglas Memorial Hospital have appointed Miss Catherine Ross as the new superintendent. Miss Ross, a native of Nova Scotia, has, until recently, served as Deputy Director of Displaced Nurses with UNRRA in Germany.

* * * *

KITCHENER. Miss Anne C. Ballantyne, Reg.N., has been appointed supervisor of nurses at the Freeport Sanatorium here. Miss Ballantyne is a graduate of the administration course for nurses at the University of Toronto.

* * * *

FORT WILLIAM. Announcement has been made of a $200,000 provincial grant for an additional wing to the Fort William Sanatorium. The grant is to be administered through the Indian Health Services branch of the Department of National Health and Welfare, and will provide 75 more beds for Indian patients in the sanatorium.

* * * *

PETERBOROUGH. City Council here has approved a recommendation to assist in building a 52-bed addition to St. Joseph's Hospital. Estimated cost of this proposed expansion is $335,000.

* * * *

ST. THOMAS. The St. Thomas Memorial Hospital Annex was officially opened in November. This new $35,000 hospital wing provides 59 additional beds to the city's accommodation for the sick.

* * * *

TRENTON. Construction has commenced on the new 50-bed Memorial Hospital here. This structure, to be built of solid brick, concrete and steel, has been made possible by contributions from adjoining counties and townships and a promise of a provincial grant of $50,000.

Saskatchewan

REGINA. It has been announced by the provincial Red Cross Commissioner here that four additional Red Cross Outpost hospitals will be operating soon in the northern part of Saskatchewan. One is located at Buffalo Narrows, one hour's flying time north of Ile a la Crosse, and the other at Stony Rapids, at the eastern end of Lake Athabasca. These two hospitals have been built by the provincial government, and the Red Cross has taken responsibility for equipment and maintenance.

* * * *

SASKATOON. Excavation is proceeding for the $7,000,000 university hospital building here. The wing housing the cancer clinic, operating rooms and laboratories will be constructed first. When complete the hospital will be a six-storey structure containing 575 beds, 150 to be provided by the Veterans' Affairs Department.

(Concluded on page 74)

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Provincial Notes (Cont.)

Alberta

MEDICINE HAT. Construction of a new maternity wing and renovations to a private wing are nearly completed at the General Hospital here, increasing its capacity from 140 to 185 beds. An enlarged record department, situated in the basement, and a modern signal system are also new features of the hospital.

* * * *

TOFIELD. The new Tofield Municipal Hospital was officially opened in November. This 20-bed hospital is equipped with up-to-date x-ray facilities, sterilizers, nursery and living quarters for the staff.

* * * *

WAINWRIGHT. The Canadian Army training centre hospital at Wainwright has been leased by the provincial government as accommodation for mental cases. This new institution will help to provide more adequate care for mental patients in the province.

British Columbia

ESSONDALE. Tenders are being called for the construction of a 220-bed hospital and powerhouse at the Provincial Mental Home here. The hospital is to be a permanent structure of concrete fireproof throughout.

* * * *

PORT ALBERNI. The campaign for funds to assist in the erection of a new district hospital here is meeting with fine success. The local drive aiming at $100,000 for the current year (60 per cent to go toward the new hospital and the balance to local and national welfare organizations) has now reached 75 per cent of its objective.

* * * *

PRINCE RUPERT. The first floor of the Prince Rupert General Hospital, which has been closed since May, 1945, was re-opened last month for the handling of men's medical cases. Renovation of the former military hospital, now a part of the general hospital, is also under way.

VANCOUVER. Construction has started on a new cancer treatment and diagnostic clinic here. Adjoining the present clinic, the new structure will cost $30,000 and is expected to be in operation by the end of this year. Funds for the project were obtained in the 1947 "Conquer Cancer Campaign" sponsored jointly by the B.C. Cancer Foundation and the British Columbia Branch of the Canadian Cancer Society.

* * * *

ZEBALLOS. The Zeballos Hospital, closed during the war, was re-opened recently as a result of grants from the provincial government and from private sources. Originally built by the Canadian Red Cross, the hospital will now be operated by the Zeballos Hospital Society.

"Only by taking decisive action to provide professional education in much greater volume can we hope to achieve the high standard of public health to which people are entitled." — *Dr. Thomas Parran, Surgeon-General, U.S.P.H.S.*

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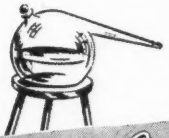

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Alberta Hospitals Propose Province-wide Care Plan

THE annual meeting of the Associated Hospitals of Alberta was held on November 26th in conjunction with the Institute for Administrators (see page 32). A number of important matters were discussed and agreement was reached as to the appropriate action to be taken.

Uniform Accounting and Rate Structure

The desirability of a uniform system of accounting in hospitals was considered, and the association agreed to go on record as favouring the development of a uniform rate structure as a first step toward the desired accounting system. A resolution was adopted instructing the incoming executive to complete the necessary investigation and work toward drawing up schedules satisfactory to all hospitals concerned. Emphasis was placed on the principle of basing all negotiations for the purchasing of hospitalization upon the rate structure so established.

Central School of Nursing

The shortage of graduate nurses in the province was discussed and the consensus was that the most satisfactory means of increasing the number of nurses would be a central school of nursing. In view of this, a resolution was passed endorsing the plan to establish a central school and indicating the willingness of the meeting to co-operate in a publicity campaign to acquaint the communities concerned and the government of the necessity for such an experimental school.

Blue Cross Hospitalization Plan

The question of hospitalization plans was discussed, and it was noted that the College of Physicians and Surgeons in the province were planning to introduce a group insurance plan for the complete payment of medical and surgical expenses. The opinion of the meeting was that hospitalization plans are most effective if province-wide in scope. Accordingly, a resolution was passed instructing the incoming executive to contact all hospital groups operating hospitalization plans in an effort to have them amalgamate into one province-wide Blue Cross Plan for hospital care.

Of concern to the association was the medical care of displaced persons being brought into the province by the Department of Immigration. A motion was agreed upon recommending that the Department of Veterans Affairs should take over this responsibility. It was stressed in this recommendation that any illness occuring during the first year should be treated to finality.

Officers for 1948:

President: Mr. J. Gallant, Edmonton.
Vice-president: Mr. N. McClellan, Vermilion
Secretary-treasurer: R. L. R. Adshead, Edmonton
Executive: Mr. L. Wilson, Drumheller, Mother Immaculata, Lethbridge, Mr. C. O. Savage, Innisfail, Dr. J. Heaslip, Calgary
Chairman, Economics Committee: Mr. M. Ross, Edmonton

Sanatorium Christmas

(Continued from page 31)

infirmary wards from 3:00 to 5.00 p.m.

Christmas dinner for staff and ambulant patients is held at 6:00 p.m. All staff, including those who live in the village, attended with their families. Visitors are welcome. When the doors are thrown open some 275 people troop into the gaily decorated dining room and wend their way past the waitresses standing in line inside the entrance. Places having been found, grace is said and then all seat themselves at the festive board. Christmas crackers are pulled and paper caps donned by all. The waitresses now emerge from the kitchen in a long line each carrying a turkey. Carving the Christmas turkey is traditional. A man at each table having been previously chosen for this rite, all carvers, stand to their work, vieing in speed and dexterity.

It is customary to place trinkets in the Christmas pudding and when this has been served the Superintendent rises and asks those who have found the various articles to stand, at the same time reading off the old prophecies that go with them. With the coffee the Superintendent again rises and requests those who are having their first Christmas dinner in the dining room to stand. Next those with two Christmas dinners and so on down the years until the oldest old timer, who will have 33 years this Christmas to his credit, arises to receive his ovation.

At eight o'clock all gather in the assembly hall for the concert. The program consists of musical selections, both instrumental and vocal, dances, pantomines, recitations and skits. As children are so much a part of Christmas we always have the little ones contribute to the performance. This is something the patients really appreciate. It is almost traditional that one or more of the patient items be a take-off on the staff, the medical staff usually suffering. This is taken in good part and adds to the general enjoyment. The medical staff always put on a skit or short act of some kind, the funnier the better.

At various times during the evening the Superintendent reads Christmas greetings sent from other institutions, Board members, old staff members and old patients. We still hear from many old patients discharged some 15 to 20 years ago. It may be of interest to note that we use the Christmas menus as Sanatorium greeting cards and send them to other institutions, Board members and business firms. Telegrams are sent to sister institutions in the Province and to various officials within our organization.

After it is all over a letter is composed describing the events of the current Christmas season. This is mimeographed and a copy is mailed to all who have sent greeting cards that year. Thus we maintain a link with the past and a continued outside interest in our activities at Ninette. Perhaps it helps to keep alive the old time spirit of Christmas and even to project it into the future.

As the concert draws to a close one cannot help but feel how very worthwhile the celebration of Christmas is in a sanatorium. A sanatorium audience cannot be beaten anywhere for appreciation and wholehearted enjoyment of a festive occasion. The entertainment in itself

(Concluded on page 80)

Death Certificates

(Concluded from page 56)

Saskatchewan

"Assuming that you refer to the conditions under which a registered nurse may issue the usual death certificate required before a burial permit is issued, I wish to advise that there is no provision in this province authorizing the issue of such a certificate by a registered nurse unless such nurse is, and issues such certificate in the capacity of, a physician or coroner."

—J. C. Treleaven, Acting Deputy Attorney General.

Alberta

The following memorandum has been received from the Bureau of Vital Statistics of the Province of Alberta:

"While the number of deaths that are registered where a physician has not been in attendance during the last illness are now comparatively few, cases occasionally occur in the rural districts where the district nurse only has been in attendance. In these cases a certificate of cause of death signed by her is accepted. When a death occurs in a rural district without any medical attention of any kind, the district registrar may prepare a certificate to take the place of the medical certificate upon statements obtained from relatives or other persons, or he may refer the case to the Coroner for investigation. After investigation, the Coroner issues a certificate of cause of death. Most of these cases, as are all cases of sudden or accidental death in the country, are referred to the nearest R.C.M.P. Constable who investigates the case with the Coroner. We subsequently receive a copy of the police report covering the investigation."

—A. Packford, Deputy Registrar General.

British Columbia

"I may say that I know of no legislation in this Province dealing with this matter. In remote districts, however, cases may arise where there is no medical practitioner available, and there happens to be a nurse, and I believe that in some of these cases a certificate of death has been made out by the nurse and has been accepted by the Vital Statistics Branch here, there being no medical man present."

—Eric Pepler, Deputy Attorney General.

Sanatorium Christmas

(Concluded from page 78)

may not always be first class, though usually of surprisingly good calibre. However, even the lame performer is safe within the tolerance of the family circle. Many items hold special significance because of their local colour which gives an intimacy in enjoyment that is unique and found only in groups of this nature.

In closing it should be said that the Christmas season at Ninette is one that needs to be kept for its own sake. Moreover, we feel that any patient over-activity at this season is outweighed by the therapeutic benefits of the brief holiday from the grind of cure-chasing. Patients start the New Year improved in morale and with happy memories to tide them over the long winter days to come.

U. S. Army to Build World's Biggest Medical Centre

What is planned to be the greatest medical centre in the world will be built at Forest Glen, Maryland, by the Corps of Engineers for the Office of the Surgeon General (U.S.A.), according to a recent announcement made by Major-General Raymond W. Bliss, the Surgeon General. The initial cost of this mammoth undertaking, designed to keep pace with technological advances in all fields, is estimated at around $40,000,000, and construction will be supervised by the District Engineer, Washington, D.C.

The project will comprise a 1,000-bed general hospital, capable of expansion to 1,500 beds; the Army Institute of Pathology building; the Army Medical Museum and Centre Administration building; Central Laboratory Group buildings; and the Army Institute of Medicine and Surgery. A working library, animal farm, quarters for the staff and other buildings are included in the plans. Site of the research centre will be just outside Washington, and will have the advantage of close relationship to the Walter Reed General Hospital, the Naval Medical Centre, the medical schools of the District and the proposed new Washington Medical Centre. In addition, members of the District of Columbia Medical Society, among them some of the finest specialists in the world, and medical experts from other government departments, will be available for consultation.

The plans provide that 200 beds shall be specifically designated as research beds and that these be so located as to be physically accessible to research activities of the various institutes and central laboratories. In addition to details of latest equipment and arrangement the hospital will also have a gymnasium, bowling alleys, swimming pool, auditorium and conference rooms, post exchange, barber shop, snack and beverage bar, post office, library, bank, game rooms and tailor shop. These facilities will be included in, or directly connected with, the hospital building and will be accessible to patients and post personnel. The estimated floor space for the initial building is expected to be 650,000 square feet.

The proposed new Centre will serve to bring together many important units now scattered in various parts of the United States.

Electrical Hazards C.S.A. Code

(Concluded from page 62)

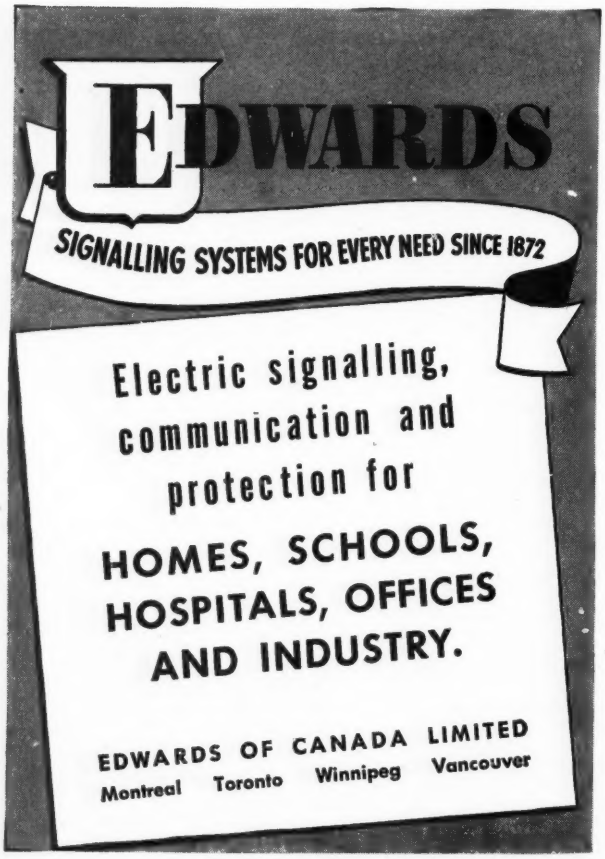
for use in Class I, Group C locations. Motors should be of a type approved for use in Class I, Group C locations and should be installed outside the ducts.

Temperature and Humidity

Temperature and humidity maintained in operating rooms should be chosen on the basis of the well-being of patient and personnel. High humidity will reduce the hazard of electrostatic spark discharges under certain conditions but is not sufficiently reliable for their complete elimination.

Windows

Windows in hazardous locations should be kept closed.



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